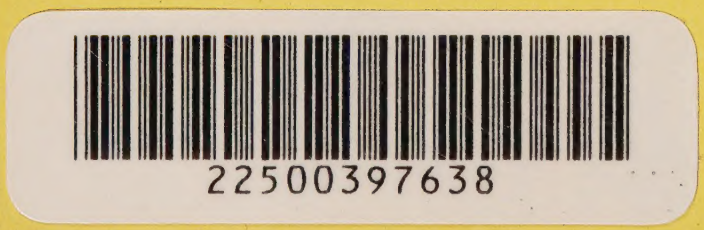

PROCEEDINGS

MEDICO-CHIRURGICAL SOCIETY

OF

MONTREAL.

1883-4-5.

PUBLISHED BY THE SOCIETY.

Montreal:
PRINTED BY THE GAZETTE PRINTING COMPANY.
1886.

PRESIDENTS

OF THE

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL

SINCE ITS RE-ORGANIZATION IN 1870.

---

*G. W. CAMPBELL, M.D.....	1870	F. W. CAMPBELL, M.D....	1877
*H. PELTIER, M.D., ED.....	1871	H. HOWARD, M.D.....	1878
R. P. HOWARD, M.D.....1872,	1879	GEO. ROSS, M.D.....	1881
W. H. HINGSTON, M.D...1873,	1880	R. KENNEDY, M.D.....	1882
*JOHN REDDY, M.D.....	1874	T. A. RODGER, M.D.....	1883
R. T. GODFREY, M.D.....	1875	T. G. RODDICK, M.D.....1884-85	
G. E. FENWICK, M.D.....	1876		

SECRETARIES.

T. G. RODDICK, M.D., 1870-74.	R. MACDONNELL, M.D., 1877.
*JNO. BELL, M.D., 1875.	O. C. EDWARDS, M.D., 1878-81.
A. A. BROWNE, M.D., 1876.	A. HENDERSON, M.D., 1882.
*J. D. CLINE, M.D., 1877.	D. F. GURD, M.D., 1883-85.

*Deceased.

CONTENTS.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Oct. 26th, 1883.

T. Rodger, M.D., President, in the Chair.

Maggots in the Ear.—Dr. Osler exhibited for Drs. McLean and Duncan, of Fergus Falls, Minn., five larvæ of *Musca lucilia* which were removed, with sixteen others (all alive), from the ear of a man aged 24.*

Dr. Osler remarked that many such cases were on record, but the large number of larvæ in this one was remarkable. They are invariably in connection with suppurative disease of the ear.

Aneurism of Abdominal Artery and Superior Mesenteric Artery.—This patient, aged 49, a printer by trade, had been brought before the clinical class in the summer session on two occasions. He presented a large aneurism in epigastric region, which projected as a prominent tumor and had considerable mobility. The only symptoms were pain in the back and loins and distress after eating. Had noticed the pulsation for a year, the tumor for only two months. Palpation revealed a curious sausage-like projection from the main tumor, freely movable, and feeling like a dilated vessel. Death took place suddenly from rupture of the sac into the peritoneum.

Dr. Trenholme exhibited a small body, sausage-shaped, about 3 inches long and 1 inch in diameter, somewhat dense structure, and apparently having a capsule, which had been passed by a patient with the following story:—A man, æt. 50, hard drinker, was taken ill with severe vomiting and pains in the

* *Vide* "Can. Med. & Surg. Journal," vol. xii., p. 271.

stomach and abdomen. Pulse quick, but no elevation of temperature. Bowels constipated, urine very high-coloured and scanty. External and internal treatment failed to give entire relief, and though the bowels were freely opened by purgatives, and the pain alleviated by sedatives, yet the vomiting continued for several days, copious and of a decidedly grumous character. These severe symptoms abated, but still there was occasional vomiting, accompanied by severe colicky pains and great distension of the abdomen. About ten days from the onset of his illness, while defecating, he passed the body now exhibited. The nature of this growth or body is not very apparent to the eye or touch, possibly an organized blood clot or an enlarged gland. Perhaps Dr. Osler, who has it in charge, will give more definite information as to its nature at the next meeting.

Dr. Trenholme also exhibited a *pair of ovaries and tubes* removed about ten days ago from a patient in St. Catharines. This being his *sixth* successful case in succession since May last. The ovaries appear to be healthy, but both tubes have been the seat of salpingitis, and are considerably diseased. The patient, æt. 28, has always had more or less suffering at menstruation. About five years ago sufferings increased, and were accompanied by general nervous depression and weakness, suffering especially in her head. About three years ago was under treatment for anteflexion and stenosis, which were relieved, but the treatment greatly intensified her head troubles and general nervous exhaustion. Since that period has been constantly an invalid, often not being able to see her friends, or hear any conversation, remaining in her room alone; sleeps badly, and often has what she describes as "wave after wave of nervousness," and feels as though she was going mad. The operation was undertaken more with a view to relieve the nerve symptoms than for any pelvic suffering, and so far the patient has made a rapid recovery from the operation, and declares she feels better than before. Dr. Osler took the specimen to report upon at the next meeting.

Dr. Henry Howard read a paper on "*Division of Labor and*

the Etiology of Disease." He said that, in division of labor, nine out of every ten of our medical men took up some particular specialty, and upon this specialty the profession and the public looked upon them as authorities. This accounted for the rapid strides made in medical knowledge during the last quarter of a century ; and not only had this division of labor been confined to the medical profession, but its necessity had been recognized by the agricultural, the mechanical, the commercial and the travelling classes. After dwelling at some length on this subject and on the physiology of matter, he said that in diagnosing diseases of the human frame, we find certain physical symptoms or phenomena, and in looking for physical cause, we look for abnormal physiology of parts, or pathological defects, to account for the physical symptoms or phenomena that present themselves. In conclusion, Dr. Howard said : " You may say to me, suppose we know the physiology of all matter, and the pathology of all diseases, what then ? Would we be the better able to cure disease or find a remedy for the removal of these diseases ? Well, whatever chance we may have when we come to obtain this knowledge, we can do but very little without it. When that time comes, however, I believe the pharmacologist will find the remedy for the disease. I agree with that eminent physicist, Mr. Huxley, when he says, ' It will, in short, become possible to introduce into the economy a molecular mechanism which, like a very cunningly contrived torpedo, shall find its way to some particular group of living elements and cause an explosion among them, leaving the rest untouched.' No wonder that such a man would come to such a conclusion when he so ably and truly describes man. His words are : ' The body is a machinery of the nature of an army ; each cell is a soldier ; an organ a brigade ; the central nervous system, head-quarters and field telegraph ; the alimentary and circulating system, the commissariat.' "

Several members spoke approvingly of the new Anatomy Act, and it was suggested that our Society should let the Government know that we would support them against the threatened serious opposition to this Act, which is now being

agitated chiefly by political persons. Others of the members thought the less done the better, as the opposition would die a natural death.

Dr. Rodger read the following notes of a remarkable case which occurred in his obstetric practice:—

On the morning of the 10th of October last I was requested to visit a Mrs. L., aged 32, whom it was said had been ill all night with great difficulty of breathing. Found the patient in bed, half sitting, half reclining on her side, and propped up with pillows. Her countenance was somewhat anxious, face slightly livid, eyes staring, breathing very hurried and short, and complaining of great tightness over the chest and abdomen, with a sense of suffocation. This being my first visit to her at this time, and not knowing that she was pregnant, I at once examined her chest; found heart and lungs normal, but was struck with the size of the abdomen. Her feet and legs were slightly œdematous, but no great amount of swelling of vulva. There had been slight pains at long intervals all night, but the patient said not like labor pains, though she thought she ought to have been confined some time during the month of September, having, as far as she could recollect, menstruated for the last time about the beginning of the year. The size of the abdomen being so much out of proportion to anything I had ever witnessed before, I began questioning as to her condition for some time back. She told me nothing out of the way was noticeable in the size of the abdomen until between the sixth and seventh months; that never at any time could she say she felt any distinct movements of the child, such as she experienced with her other children; that she had suffered considerably at different times from irritation of the stomach—in fact, had often great difficulty in retaining food. A vaginal examination revealed the os to be high up, dilated about an inch, edges tense, but thin; membranes entire, but no presentation could now be felt. Examination of the abdomen gave dulness on percussion throughout; no movement nor outline of the fœtus made out. Could not hear either the heart sounds or placental bruit. With the assistance of the friends present, I changed her position to one which I thought more favorable, and

which might assist me in detecting a presentation, but all without any effect whatever. The distress of the patient being so great, I felt that some measures would require to be adopted at once for relief; so I gently dilated the os until I succeeded in passing the greater portion of my four fingers within the uterus, taking care, at this point, not to tear the membranes. Still no fœtus could be felt. Satisfying myself as to the toughness of the membranes, I passed my whole hand between the latter and the walls of the uterus, and endeavored to rupture the membranes with my finger, but failed. Without withdrawing my hand, I passed with the left a knitting needle, when the rush of waters was tremendous. Continuing my search for the child, my arm acting as a plug in the vagina, I could find nothing in the uterus proper, having passed my hand all around the walls, but, at the upper end or fundus, a circular opening about the size of a silver dollar, edges somewhat thick, and unyielding to ordinary force by the fingers. Passing my forefinger through this new opening, I touched the mouth, nose and eyes of the child, then gradually succeeded in getting in a second finger, when no forehead could be felt—in fact, no head. With the gradual escape of some portion of the amniotic fluid, I found that I could use more force with my fingers in dilating, due to this second uterus, if I may so call it, being brought nearer to my hand. Owing to the alarming condition of the patient at this point, and fearing delay might not serve any good purpose, especially if the escape of the amniotic fluid was permitted, there being a possibility of collapse, I determined at once upon version, and set to work to force my hand into the interior. After considerable resistance had been overcome, both feet of the fœtus were grasped, completing the delivery of a still-born acephalic male child, weighing about six pounds. Fluid Ext. Ergot was given to ensure uterine contraction, and after the delay of a short time, the placenta came away by gentle traction with the hand, followed by slight hemorrhage. The woman was not in a condition to warrant further interference, otherwise I should have liked to have passed my hand and further investigated the interior of the uterus, but feared that possibly such procedure might be attended with bad results.

This is now the sixteenth day since the patient was confined, and I may state that she is doing well, no bad symptoms having appeared so far in the case. I confined the woman three times before, her labors being perfectly natural.

Dr. Rodger had a sketch on the blackboard shewing the relation of the parts before delivery.

Dr. Trenholme remarked with regard to Dr. Rodger's most interesting case, that the position of the opening being at the "upper part of the fundus," the possibility of tubal or utero-tubal gestation in any of its forms, was excluded. Had it been tubal or tubo-uterine, the opening would have at least not more than 4-5 of the distance from the os to the fundus. It was also impossible that the opening leading from the large cavity, containing the waters to that in which the fœtus and placenta were, could be a pathological opening, as it was readily dilated, turning easily effected, the fœtus and placenta removed and "good contraction" secured. Hence it must be simply an hour-glass contraction of a uterus containing a fœtus dead for over three months and accompanied by this immense quantity of amniotic fluid. This view is still further strengthened by the fact that the uterine decidua and that of the cavity containing the child *were continuous and one* throughout, there being no membranes to puncture over the aperture where the face of the child presented. The case is a most interesting one and happily conducted to a successful issue.

Dr. Shepherd was of the opinion that it was a case of tubal pregnancy.

Dr. Rodger thought it was a case of hour-glass contraction, but thought there was nothing to preclude its being tubal pregnancy.

Dr. Campbell mentioned a case where serious symptoms followed the taking of a three-drop dose of a 1 per cent. solution of nitro-glycerine by a patient suffering from angina and advanced mitral disease. Three drops were taken instead of one, as prescribed, in the hope that more benefit would be gained. Shortly after swallowing the three drops a rash like that of scarlet fever came out, particularly on the chest. This disap-

peared in five or six hours. The tongue was dry, and in twenty-four hours he passed five times his usual amount of urine. The heart beat quickly, but there was no rise of temperature.

Dr. H. Howard said this agreed with his theory that the blood had nothing to do with rise or fall of temperature, which was alone influenced by the nervous system.

Dr. Campbell also spoke of the continued success he is having with nitro-glycerine in epilepsy.

Dr. Osler mentioned that he had three cases of *petit mal* where he was using it, so far with decided benefit in only one case.

Dr. Reed brought up the matter of "Collective Investigation of Diseases," and urged the Society to follow out a plan similar to that adopted by the British Medical Association.

Several members spoke in favour of Dr. Reed's proposal, after which Dr. Hingston proposed that Drs. Reed, Osler, and Cameron be named a committee to draw up the necessary questions, etc., with reference to the investigation of Enteric fever. Carried unanimously.

Stated Meeting, Nov. 9th, 1883.

Dr. Rodger, President, in the Chair.

Division of Femoral Artery.—A specimen illustrating a somewhat novel source of injury was sent to the Society by Dr. A. Henderson, of Calgary, N. W. Territories. The deceased from whom the specimen was taken was a cow-boy in the employ of the Stewart Ranche Company and was employed in killing cattle for the C. P. R. construction twenty miles west of Calgary. He was in the habit of carrying his knife unsheathed, hanging to the horn of the saddle, and while taking aim at a steer with his rifle, his horse becoming restive he raised his leg to steady himself when the point of the knife pierced his left thigh about its middle and to the inner side. Profuse hemorrhage followed which proved fatal within an hour. A

dissection of the part shewed that the femoral artery had been divided a short distance above where it pierced the adductor magnus muscle. As seen by the specimen, the artery was completely divided by a clean cut, while the vein lying alongside failed to give evidence of the slightest scratch.

Dr. Osler exhibited the following pathological specimens:—

Cancer of Liver, with much-enlarged Glands.—Dr. Phelps, of Chateauguay, N. Y., sent this specimen to Dr. Osler with the following history: "Three years ago the patient, a woman aged 27, noticed a bunch protruding at ensiform cartilage which enlarged slowly. Was treated with blisters and escharotics. As it still grew she consulted me last spring. I found a nodulated tumor extending from the ensiform cartilage midway to umbilicus and about eight inches wide. It pressed firmly against the margins of the ribs and was but slightly moveable. It seemed to be covered by skin only. Percussion gave a tympanitic note over its whole extent. It could be grasped at lower margin and moved freely, but seemed to be attached at the ribs. Up to this date she enjoyed good health, had no pain, only a sense of fullness. Was at a loss for a diagnosis, so sent her to Dr. ——, of Montreal, who said it was an enchondroma of the ensiform cartilage which extended between the sheaths of the rectus muscles. He advised extirpation if it continued to enlarge. In June I was sent for to perform the operation; the messenger stated that another enlargement had appeared further to the right. Drs. Bates, Gay, and Furniss, of Malone, accompanied me to her residence where we proceeded to administer ether in order to carefully examine, so as if possible, to determine whether the disease was extra or intraperitoneal. We discovered not only the large right side of the liver but the large mass which proved to be the enlarged mesenteric glands. It is not necessary to say that the operation was deferred till after the patient had climbed the "golden stairs," which took place October 25th, 1883. Dr. Furniss and myself performed the *post mortem*. Skin was cachectic, limbs bloated, and abdomen enormously distended. We removed about 40 lbs. of serum from the abdomi-

nal cavity. Over the tumor the abdominal walls had been all absorbed excepting the skin and peritoneum. The growth was not adherent in front. The stomach and transverse colon were both underneath of, and attached to, the left lobe of the liver. The pancreas was healthy, the kidneys, ovaries and uterus normal. The thorax was not opened. The disease began as a cancer in the left lobe of the liver, pressing forward and downwards absorbing the abdominal walls and making its appearance at the ensiform cartilage as a nodule. Its overlapping the stomach and colon accounts for the tympanitic note on percussion. The enlarged mesenteric glands and right lobe of liver made up the second tumor felt by the patient. Death evidently took place from suffocation caused by over-distension with fluid.

Fibroid Disease of the Stomach.—This specimen was sent to Dr. Howard by Dr. Powell, of Ottawa. It was removed from a man aged about 60, not intemperate, but a good liver. He had consulted several doctors who all inclined to a diagnosis of scirrhus of the stomach, as the symptoms pointed that way. The stomach was contracted and much thickened owing to fibroid deposit in the mucous membrane and muscularis.

Laceration of Brain.—This specimen was removed from an hospital patient, a lumberman, suffering from an enlarged spleen and leukæmia for over a year. While in hospital he appeared to be doing well, when one night he suddenly became comatose and died in a few minutes. The *post mortem* revealed extensive laceration of the brain substance from hæmorrhage.

Ovarian Cysts in an Infant.—Taken from a child of ten weeks shewing cystic disease of both ovaries.

Dr. Alloway exhibited a "Jannison's Uterine Irrigator" which he had been using for some time past, and which had given him more satisfaction than any other instrument devised for the same purpose. It consisted of a flexible metal tube, so bent that it formed a third arc of a circle, the diameter of which latter was twelve inches. On the outside of this tube ran another of much larger calibre, but not so long, the space between the tubes answering the purpose of providing for an immediate return-stream from the uterus. He related the

history of a patient who, having expelled a 2½ month's decidual mass into vagina received an intrauterine injection of warm carbolized water from a fountain syringe, armed with an ordinary hard rubber tube, which did not admit of the immediate return of the fluid. About ¾ of an hour after injection, the patient was seized with pain over the region of the left broad ligament, chill and faint feeling, followed by elevation of temperature (102° F.) and pulse 110 and severe paroxysmal attacks of dyspnœa. After the administration of a hypodermic of Battley she recovered from pain and symptoms. Dr. Alloway attributed the condition of his patient to the entrance of the solution for a short distance of the left Fallopian tube, that slight hyperæmia of the delicate lining of the tube would follow the irritant, and in this way account for the pain and other reflex nervous symptoms manifested. He did not think the symptoms due solely to destension of the uterine cavity by the fluid, as there was no expression from the patient of even discomfort, at time of injection. He thought it of little importance what term would be used to designate the condition; it was the cause of the apparently alarming symptoms which were of interest to him, and which he thought resulted from the use of a tube which did not provide for an immediate return-stream from the uterus. He had injected tbe uterus under the same circumstances, many times before with the same kind of imperfect tube, but had never witnessed such a condition. He thought probably it would be well to limit injection in such cases. to those in which the discharge were fœtid; and this was one reason why he brought his experience in the matter before the notice of the society, with Jannison's tube however, he would feel perfectly safe under all circumstances.

Axis Traction Hook.—Dr. Alloway also exhibited an 'Axis Traction Hook" of his own device. He claimed that the hook answered all the purposes of Tarnier's instrument when passed into the lock of any ordinary forceps and traction made by the hook alone. Traction could be made in any direction pleasing to the operator, and the hook could be used in this way whether the head was arrested at the brim or low down in the

cavity of the pelvis. Dr. A. used the hook almost solely with Simpson's short forceps, and found that the handles of the forceps and those of the hook came when applied into such convenient relationship, that more power, if necessary, could be exerted, than with Simpson's long forceps, without the hook. Dr. A. related the history of a very interesting case where he first used the Traction Hook. The patient had been, some eighteen months before, operated on by Dr. Roddick for the removal of a large ovarian cyst (40 pounds). The walls of the abdomen, so far as the muscular structures were concerned, did not unite, or the line of union had become absorbed, and allowed an enormous ventrel hernia to take place. When seen at three months' gestation the whole of the intestines and loose adnexa came down in a horn-like pouch between her legs. They had to be replaced and sustained by a suitable truss. During labor almost complete anteversion of the uterus would take place at every pain, and the condition was quite uncontrollable. The axis of the pelvis and that of the uterus were almost at right angles to each other, so that the patient could never have delivered herself unaided. Dr. A., though a firm believer in Tarnier's principle, alluded to the great cost, complex nature, difficult application, and trouble of keeping clean, of Tarnier's forceps, which would tend greatly to prevent the instrument coming into anything like general use. That his simple inexpensive instrument would in many instances prove serviceable when Tarnier's instrument was not at hand.

Dr. Trenholme quite agreed with Dr. Alloway as to the uselessness of the first tube he spoke of, and that he had done well to cast it aside. Dr. Trenholme, however, would go further, and maintained that to inject the uterus, using any manner of tube after the contents had escaped into the vagina and been removed, was an unwarrantable proceeding, and fraught with danger, as the case related shewed. Uterine irrigation was seldom called for, and ought not to be resorted to, save when the decomposing contents, as revealed by the offensiveness of the discharges, shewed that there was danger of putrid absorption. Dr. Trenholme's experience in abortions enabled him to speak decidedly on this subject.

Dr. Trenholme said that the instrument exhibited by Dr. Alloway did not afford one single advantage possessed by Tarnier's forceps. In the first place traction by Dr. Alloway's hook was made at the lock, far from the points or blades, and then the shortness of the handles gave no power to engage the head in the axis of the brim as could so easily be done by Tarnier's. For his part he had used the Hodge modification of the long French forceps in all high operations with ease and success in cases where delivery by the forceps was warrantable; for we must not forget that there is a limit to the force which cannot be expressed. With the patient on her back and these long forceps, we can with perfect ease engage the head in the brim. The left hand sustains the handles, while the right hand over the lock brings down the head with all the force we would be warranted in using. When this fails, turning should be resorted to so as to open the shortest diameter of the child's head to the antero-posterior diameter of the mother's pelvis.

Dr. Campbell said that the uterus after abortion very seldom needed washing out. Has known colic to follow an injection into the vagina for leucorrhœa. Once saw serious symptoms and death follow an injection in a woman who had recently been confined.

In reply to Dr. Trenholme, Dr. Alloway felt from his experience in the case recited, that if there was no fœtor to be detected in the discharge, and if a uterine tube similar in design to Jannison's was not at hand, it would be better not to inject at all. But if there was evidence of decomposition within the uterus, he would recommend the use of such a tube as the one he used, or better, a common elastic catheter. The solution he was using at present was $\frac{1}{2000}$ parts of corrosive sublimate.

Obstetrics.—Dr. Trenholme related the following case:—Was sent for last Monday by a *confrère* to a woman in labor with her third child. Two physicians had failed to deliver with the forceps. He found the os fully dilated; antero-posterior diameter at brim was $3\frac{1}{4}$ inches. Had had a natural labor with her first child; the second had to be delivered with forceps.

Dr. T. found the child was lying diagonal to the abdomen. He proceeded to turn, his hand first feeling the promontory of the sacrum bulging out; there was also hour-glass contraction a little above the os, and again near the fundus, which caused great difficulty in moving the child. However, after some time he succeeded in delivering all but the head, which Dr. Armstrong opened, as by no safe efforts could it be loosened.

Dr. T. said the trouble was caused, not so much by the deformity, as by the two spasmodic contractions. He had seen a similar case before, where, from repeated powerful attempts to deliver with the forceps, the uterus around the os was bruised into a pulpy mass, causing the death of the woman.

Dr. Cameron had seen a case something similar, requiring evisceration, owing to ergot having been wrongly used to hasten a tedious labor from early escape of liquor amnii. No amount of traction was of any avail.

Dr. Alloway thought that cases where the waters broke early and caused spasmodic contraction on the child were not very unusual.

Dr. Ross thought the cause in Dr. Trenholme's case was obscure. He did not believe that spasm alone could resist strong efforts at traction, especially as the head was found very large. He thought it should hardly be called hour-glass contraction. Had only seen two cases of hour-glass contraction, and in both it was after the birth of the child, and where the placenta was retained above.

Dr. Trenholme replied by saying that he thought it not unreasonable to put the difficulty down to spasm, as in his previous case the woman had plenty of room, yet was unable to deliver with forceps on account of spasm gripping the child.

Dr. Rodger agreed with Dr. Ross that other causes appeared to be present to account for the difficulty.

The following resolution of condolence was passed by the Society, to be sent to the family of the late Dr. Trudel:—

"That this Society desires to express its sense of the great loss sustained by the profession and society generally in the death of Dr. E. H. Trudel, whose long and honorable career as a man and physician

secured to him the consideration and esteem of the citizens generally, and whose high scientific attainments and facile mode of expression enabled him for many years to fill the chair of Obstetrics in the Montreal School of Medicine with distinction to himself and advantage to the students."

Stated Meeting, Nov. 23rd, 1883.

T. A. Rodger, M.D., President, in the Chair.

Uterine Fibroid.—Dr. Gardner exhibited a number of fragments, making up a fibrous polypus he had removed from the uterus of a patient sent to him by Prof. Geo. Ross. The patient, aged 48, unmarried, presented no evidence of ever having been pregnant, is very fat, and very anæmic. Gave a history of frequent hemorrhages and watery discharge for a few years, with little or no pelvic pain. On examination, the ostium vaginæ was narrow and rigid; vagina distended to the extent of the pelvic cavity by a tumor of very firm, somewhat elastic, consistence, and uneven surface, about the size of a child's head. The tumor could be partially rotated. Diagnosis from inversion could not be made by the sound, as it could not be passed around the tumor. Under ether, the fundus uteri could be indistinctly outlined through the thick abdominal wall. After incision of the perineum and orifice of the vagina, a running noose of strong twine was slipped over the tumor and drawn tight around the pedicle. A vulsellum forceps was then fixed on the tumor, and successive portions removed until at last a large portion—the residue of the growth—came away in the forceps. Very little blood was lost during the operation. The pedicle was found to be attached to the anterior wall of the uterus, above the internal os. It was trimmed off, and touched with Churchill's tincture of iodine. The uterus measured three inches in depth. The vagina was tamponed with alum cotton with iodoform—not because of actual hemorrhage, but as a precautionary measure. The patient recovered without a bad symptom. There was no pain worth mentioning, and the temperature never rose above 99.5°F. Microscopic sections made

by Dr. Wilkins shewed it to be mainly fibrous in structure. In parts, smooth muscle fibres were to be seen.

Dr. Trenholme said that the diagnosis of a polypoid tumor occupying the vagina is usually not very difficult to make out. The mobility of the tumor in this case, and the absence of vesical complication, together with the solid character of the growth, rendered it specially easy to diagnose. As to treatment, he (Dr. T.) had seen a case some time ago where the lady declined any operation, and in which he had simply twisted the tumor round a couple of times, and this cut off its blood supply. A short time afterwards the growth came away by sloughing, and the patient made a perfect recovery. In this case a similar mode of treatment would have been most likely followed with the same success without any operation whatever.

Dr. Geo. Ross said this case ought to be a warning against treating menorrhagia without making an examination. This patient was blanched and weak, and had been treated by several physicians, who never had made any examination of the pelvic organs.

Dr. Gardner also shewed the *Uterus* of a woman aged 60, who died last August. The patient, referred by Dr. Roddick, was first seen at the University Dispensary for Women on 30th January last. Unmarried; no signs of pregnancy. Menses ceased seven years ago. Health always good until a year ago. At that time she had a bloody discharge from the vagina, lasting a week; six months later a similar discharge, lasting three days; three months afterwards a recurrence of the discharge, which has continued to a slight extent ever since. It is pale, and free from clots. Intermittent hypogastric pain prevailed. On examination, abdomen flaccid, a few lineæ albicantes; cutaneous aspect of perineum slightly lacerated; vagina very narrow and atrophied, slight pale bloody discharge escaping. Bimanual examination reveals distinct enlargement and decided firmness of uterus; it is mobile. Cervix small, admitting with difficulty an Emmet's silver probe the size of an ordinary surgical probe; this entered four inches, causing free bleeding. The diagnosis then made was intra-uterine malignant growth. A month later patient returned for treatment. She was put to bed. The os was incised

bilaterally, as no laminaria tent fine enough for introduction could be got. Successive tents were then introduced, until the finger could be inserted within the uterine cavity. A soft, easily broken down growth was at once detected. The sharp curette was used freely, and a large quantity of brain-like substance removed. Hemorrhage was free, but soon arrested by Churchill's solution of iodine and plugging. The result was undoubted but temporary relief. After the pain and slight fever following the operation had subsided, symptoms returned, and in about two months later, after labor-like pains for a few days, a portion of the recurrent growth was found projecting through the now dilated orifice. The curette being again used, a much larger quantity of the same substance than at the first operation was removed. Decided, but temporary, relief again followed. After this she lived four months, suffering much from pain, fetid, but not bloody, discharge, diarrhœa, rigors, high fever and perspiration. Death took place from exhaustion. At the autopsy, made by Dr. Osler, the uterus is described as being enlarged eight times its normal size ; it fluctuates, and is soft. Examined from the vaginal os, it presents a ragged, sloughy-looking mass projecting from the upper and left side. On section, the entire inner surface is involved in an extensive sarcomatous growth which has sloughed on the surface, and presents dark shreddy, soft, disintegrating portions. The margin of the os is free, with the exception of one spot, at which the portion already noted projects. In places the growth is an inch thick. At one spot of the posterior wall the growth has perforated. Ovaries and broad ligaments unaffected. A secondary deposit was found on one pleura. During life, an elevated spot the size of a ten-cent piece existed on the anterior vaginal wall ; this had the same histological character as the growth in the uterus. Microscopic sections of the substance removed from the uterus during life showed the structure to be numerous small, round cells, with very scanty stroma.

Dr. Gardner said that in some quarters the treatment adopted might be considered as open to criticism. The most favorable cases for extirpation of the uterus were those of sarcoma. Freund's

operation by abdominal section he considered absolutely unjustifiable. If the uterus is ever to be extirpated, it should be done by the vagina, after Schröder's method. The great size of the uterus, and the narrow vagina, rendered the case unfavorable even for this method. He quite agreed with Dr. Reeves Jackson of Chicago in the views he put forth at the meeting in September of the American Gynecological Society in Philadelphia. Dr. Jackson believed that extirpation of the uterus, instead of saving life, had destroyed many years of life.

Dr. Trenholme remarked that if ever we were warranted in extirpation of the uterus, this was such a case. The uterus, though large, was free, and could readily have been brought down and removed. However, the fact of Dr. Osler finding secondary cancer deposits in the lungs shows that perhaps it was as well not to have attempted it. The smallness of the vagina, in his (Dr. T.'s) opinion, did not preclude the operation if otherwise desirable. In cases of midwifery, cases are now and again reported where the whole vagina has been torn up to Douglass's fossa, and yet the patients made good recoveries. Where necessary, we could divide the vagina and complete the operation.

Dr. Osler exhibited *a heart showing ulcerative endocarditis*, and remarked that we have had exhibited at our Society the two kinds—one, quickly fatal, with typhoid symptoms; the other, more chronic. The case was diagnosed ulcerative endocarditis by Dr. Wilkins. The patient had also acute pneumonia. The heart showed old sclerotic valves with deposit of lime salts. One of the chordæ tendineæ was ulcerated across. The cavities were dilated, and the left side hypertrophied. The spleen was also enlarged, and had numerous infarcts through it.

Case of Puerperal Eclampsia.—Dr A. L. Smith read a paper on this case. He saw his patient about the seventh month, who complained of pains in her head, back, and lower part of abdomen; said she felt silly, and saw things upside down. Micturition painful and frequent, but urine scanty in amount, high colored, and loaded with albumen. Feet and eyelids swollen. A few hours later, was sent for, as she had taken a fit. Used a

mixture of alcohol, chloroform and ether as an anæsthetic; this arrested the clonic spasms, but unconsciousness remained, broken only by recurring seizures till evening, when a consultation with a senior *confrère* was sought, and twenty leeches to the temples recommended. As the last leech fell off, consciousness returned, and she steadily regained her usual health. She was kept in bed on a strictly milk diet for several weeks, during which time the albumen decreased rapidly. Four weeks later Dr. Smith delivered her of a dead fœtus, much decomposed. She made a perfect recovery. Dr. Smith lays his success to the bleeding and rigorous milk diet, as recommended by Dr. Donkin, whom he quoted at some length.

Dr. Gardner said that the efficacy of hypodermic injections of morphia or Liq. Battley was extraordinary in these cases. He had used it frequently with very satisfactory results, even where convulsions came on weeks before labor.

Dr. Ross said the question of bleeding was divided. His own experience went against it. Only once saw good results follow, and that time the patient was a small, weak woman. He had several times seen strong plethoric women bled without any benefit. Has found chloral, given early, very useful, but morphia more reliable, and recommended hot air baths.

Dr. Trenholme said the pulse was a good indicator to bleed or not. If strong and bounding in a full-blooded person, believed bleeding to be the best treatment. If convulsions came on some time before full time, then an opiate would be good. If at full time, and os dilatable, give chloroform and deliver. He agreed with Dr. Smith's treatment of his case as regards the form of bleeding and milk diet.

Dr. Gardner spoke highly of hot air baths in these cases.

Dr. Rodger said he had treated a good many cases of puerperal convulsions. Used to bleed if the person was strong, but of late, in all cases, uses hypodermics of morphia. Chloroform or ether have not given satisfaction, nor has he seen the good effects from chloral and bromide of potassium which others speak of. Some time ago had a patient six months pregnant, with 75 per cent. of albumen in her urine, who had a convulsion. He

gave her a hypodermic of half a grain of morphia, repeating it in six hours. She had no more seizures till three weeks after. Again he used the morphia, which stopped them for two weeks more, when pains came on, and she was delivered of a dead fœtus.

Stated Meeting, Dec. 14th, 1883.

Dr. Rodger, President, in the Chair.

Syphilitic Caries of inner table of skull.—Great thickening of Calvaria—Compression and Deformity of Brain.—Dr. Osler exhibited the skull-cap and brain—The patient, a woman aged 35, had been in hospital many times during last six years with various symptoms of constitutional syphilis. Was not under regular constitutional treatment in the intervals. At one time had necrosis of right tibia. In November, 1882, was admitted with a small open sore in right parietal bone through which dead bone could be felt, and a probe passed far in between the bare bone and dura mater, towards the vertex. Symptoms chiefly debility and severe right unilateral headaches. Was in hospital several times within last year, and amyloid disease of kidney was made out. During her last illness, as on the previous occasions, her intellect was clear, and although within a few days of her death she was dull and very irritable, it was probably due to the severe pains in her head and her increasing weakness. Never had any signs of local brain disease. The headaches were very severe at night. The external surface of the skull cap was smooth, and on the right side, close to the coronal suture, was a small sinus through which a Bowman's probe could be passed. On removing the calvaria, which was moderately thickened in the supraorbital regions, a quantity of thick pus escaped. The dura mater was thickened and strongly adherent posteriorly. The internal surface was smooth and did not present any adhesions. As shewn in the specimen, the disease is confined to the contiguous surfaces of skull and dura over the frontal and part of the parietal regions. The inner aspect of the

bone in these parts is rough and carious, having an eroded, worm-eaten appearance, and covered with granulations; and towards the parietal bone, firm, solid, fibrous masses unite it to the dura. The upper half of the frontal and the greater part of the parietal bones are thickened, measuring from two to three centimetres, and are exceedingly dense. The outer surface of the dura-mater shews numerous soft granulations springing from solid fibrous tissue. The falx in its anterior half is thickened, and the longitudinal sinus is in this part obliterated. The brain shewed no trace of coarse disease; the arachnoid was a little opaque, but the pia-mater was normal. The hemispheres were curiously deformed from the pressure to which they had been subjected by the thickened bone and dura, and the pus between them. They are wedge-shaped, the base is at the occipital bones, where the greatest vertical height is eight centimetres, and the apex is at the orbital magin of the frontal lobes, where the height only two-and-a-half centimetres. This curious deformity has been brought about slowly, and illustrates the degree of pressure to which the brain may be subjected, so long as it is applied gradually.

Dr. Henry Howard referred to the remarkable absence of cerebral symptoms in such extreme compression.

Dr. Osler also exhibited a skull from the museum of McGill College, with syphilitic destruction of the entire right parietal and part of the frontal bones, with caries also of the inner table.

Epithelioma of Tongue—Excision—Erysipelas—Circumscribed Gangrene of Lung—Perforation of branch of Pulmonary Artery.—Dr. Shepherd narrated the case and showed the specimen: Thos. W., aged 42, a strong, healthy man, came to the Montreal General Hospital in January, 1883, suffering from epithelioma of the tongue; this being near the tip, only a portion of the tongue (right half) was removed with the scissors by Dr. Fenwick. Two months ago he noticed that the growth was returning, and at the time of his re-admission into hospital, under Dr. Shepherd, early in November, it was increasing rapidly. He then had an epitheliomatous ulceration of the part of the tongue that remained, and also of the right tonsil and left anterior

pillar of fauces ; the floor of the mouth was infiltrated and hard. It was decided to remove the whole tongue. This was done on November 10th. Dr. Shepherd first ligatured the lingual artery of each side by a curved incision reaching from the front of the angle of the jaw to the hyoid bone, and up towards the symphysis. After ligaturing the linguals, the tongue was removed by scissors with very little trouble and no hemorrhage, after Mr. Whitehead's method. The right tonsil (or part of it) and the anterior pillar of fauces were removed also by scissors. After the operation the patient rallied well, and was fed for two days by nutrient enemata, the mouth being rinsed out frequently with a solution of Condy's fluid. For five days the man did well ; there was no fetor from the mouth, the wound was granulating nicely, and the incisions made for tying the lingual were healing by first intention, when, on Nov. 15th, erysipelas appeared on the nose and rapidly spread over face, neck and head. Temperature rose to 103°–104°, and pulse became rapid (120) and weak. The erysipelas then spread over the chest, and the mouth now became sloughy ; fetid breath was first noticed on Nov. 27th, at which time a slight cough developed, and some bronchitis, which was looked upon as septic. No rigors or sweatings had occurred. From this time patient became gradually weaker and weaker, in spite of the stimulating treatment, and died suddenly on December 2nd from hæmorrhage. Dr. Shepherd remarked that at the time of the operation several cases of erysipelas had been admitted into the hospital from outside. With regard to the operation, he felt perfectly satisfied with it, the previous ligaturing of the linguals greatly facilitating the removal of the tongue by scissors, as all fear of hemorrhage was removed, and the scissors left a clean, instead of a bruised, surface, as is seen after the use of the écraseur. The method of operating had nothing whatever to do with the fatal result.

At the autopsy the wound looked in process of healing, and the cancerous masses had been removed. The linguals presented thrombi at the site of ligature. There was a small pocket of pus beneath the left sterno-mastoid. The trachea and bronchi were filled with blood. The right lung presented four areas of

circumscribed gangrene, the left two, each about the size of small apples. Placing the lung under water and blowing water through the pulmonary artery, bubbles escaped from one of the gangrenous regions close to the root of the lung. Dissection proved, as the specimen shows, that the hemorrhage came from a small branch of one of the main divisions of the artery, which had been opened in the necrotic process.

Dr. R. P. Howard spoke of the frequency with which gangrene of the lungs followed operations on the tongue and neck.

Dr. Geo. Ross mentioned having had a case of Cancer of the œsophagus in Hospital last winter which proved fatal from gangrene of the lung.

Sarcoma of Lumbar Glands; Perforation of the Colon; Persistent Hemorrhage.—Dr. Shepherd presented the specimen and gave the following notes: Man, aged forty-five, large, strongly built, weighing over two hundred and fifty pounds, sent for him on July 23rd, and stated that he had been seized in the night with severe pain in the back and abdomen. The temperature was 103°, pulse, 120; tongue coated; great tenderness of abdomen, with fulness in left iliac region; no vomiting; bowels had been opened several times during the night. In the evening he was worse. Temperature, 104°; pulse, 120; great abdominal distension with tenderness. On the 25th the temperature was normal, but the abdominal symptoms persisted, and there were diarrhœa and frequent vomitting. On the 29th he had a severe rigor, with temperature of 104°, and profuse sweating; tympanites and pain, with evidences of peritonitis. In a day or two he had another rigor, with severe vomiting and diarrhœa, and great abdominal distention. Dr. Ross saw the patient in consultation, and the conclusion arrived at was, that there was local suppuration deep in the iliac region. His condition at this time was very bad; pulse weak; vomiting incessant. With champagne and careful feeding the vomiting was checked, and he began to improve slowly, until in the early part of September he was able to move about the room. There was still fulness on deep pressure in the iliac fossa, but the thick layer of fat prevented a satisfactory examination.

About September 10th he began to pass a small quantity of blood—bright red—with the stools, and this increased until the daily amount was often as much as half a pint, and he became very anæmic. In the month of October he again took to bed; had severe rigors with high temperature and sweats, about every other day. At this time a tumor was made out in the hypogastric region, deep in the abdomen, fixed, solid, and not tender on pressure. Rectal examination negative. The loss of blood continued, and he got much weaker, and death took place on November 20th, after a profuse hemorrhage. The tumor had increased in size, and a week before death it seemed about the size of a child's head, and firmly fixed in the hypogastric region. The autopsy showed matting together of the coils of intestine with old peritoneal adhesions, particularly near the pelvis. The tumor was in front and a little to the left of the lumbar spine, and the sigmoid flexure was firmly united to it. The mass was readily turned out, and dissection revealed an extensive perforation of the bowel, as the specimen shows, and exposure of soft sloughing masses of the tumor. The wall of the colon was defective in an area two and a half by one and a half inches. The growth was a sarcoma of the retroperitoneal lymph glands. There were no secondary tumors, and nothing of note in the viscera. The persistent hemorrhage for over two months, had evidently come from the vessels of the exposed and sloughing part of the tumor. The repeated rigors were difficult of explanation; there evidently had been peritonitis, but whether local suppuration had occurred was not so clear, possibly it had in the process of perforation of the bowel.

Dr. Geo. Ross remarked that he had seen the case several times, and it had offered considerable difficulty in the way of diagnosis. The amount of abdominal fat prevented a satisfactory examination, and the fulness in the iliac region was thought to be possibly a focus of suppuration. Later on, when the hemorrhage occurred, and a more evident tumor could be felt, the diagnosis was made of malignant growth, and from the situation and size, probably retroperitoneal and involving the bowel.

Dr. Howard said that from the same symptoms he would

have diagnosed as did Drs. Shepherd and Ross. He congratulated them on having located the tumor so exactly.

Small Tumor on Nerve: Intense Brachial Neuralgia; Removal.—Dr. Shepherd presented a microscopic section of a small tumor the size of a bean, which he had removed from a man's arm for painful neuralgia. The patient, a thin, nervous man, stoker by occupation, was admitted to hospital complaining of severe pain in the left arm—so bad that he could get but little rest at night. His appearance was that of a man suffering intensely. The pain was more severe at times, and was situated at the insertion of the deltoid, and from there ran down the back of the arm to the elbow. He also had numbness along the ulnar nerve. Just below the posterior fold of the axilla, internal to the brachial artery, a small nodule the size of a bean was felt, which on pressure caused agonizing pain. Dr. Bell admitted the case as one of neuroma. Dr. Shepherd had removed the growth, which was found connected with a small nerve, and closely united with the cellular tissue at the back of the artery. The man has had no pain since the removal, three days ago. The section of the tumor showed a fibrous capsule, and a small, angular-celled growth inside.

A report on the nature of the tumor was requested for the next meeting.

Early Symptoms of Tabes dorsalis.—Dr. Stewart exhibited a man, aged 33, clerk, whose only complaint was of dimness of vision. He first noticed failure of his sight ten weeks ago. Three weeks after, he consulted Dr. Buller, who diagnosed the case as one of Tabes dorsalis. Twelve years ago he saw double for a week. In the year 1879, he recollects seeing double for about three days. With the exception of these two occasions, and a few days during which he was sick from measles, he has always enjoyed excellent health. He never had syphilis. The family history is unimportant. Three years ago he worked for several months in a very damp cellar.

Present state:—There is permanent contraction of the right pupil (myosis). There is loss of reflex contraction of the pupil (Argyll Robertson symptom). Both pupils readily contract on

accommodation. In addition to the loss of reflex contraction, he has also undoubted loss of reflex dilatation of the pupils. There is well marked atrophy of both discs. The patellar reflex is absent in both legs. This is the only symptom characteristic of Tabes dorsalis present, with the exception of the eye symptoms. There are no lightning pains, no paresis of the bladder or rectum, no ataxia, no delayed, lost or perverted sensations. The skin reflexes are present. Notwithstanding the absence of some of the prominent symptoms, there can be no doubt whatever about the nature of the case. It is an undoubted case of Tabes dorsalis in its pre-ataxic stage. The case is a good example of what is now generally conceded, viz., that Tabes dorsalis is essentially a disease of the sensory tracts. Three of the most prominent symptoms are failure of the normal reflexes. There is (1) loss of the reflex contraction of the pupils; (2) loss of reflex dilatation of the pupils; (3) loss of the patellar reflexes.

Treatment.—During the last seven weeks the patient has been treated with the *faradic brush* three times weekly, after the manner recommended by Rumpf of Bonn.

In reply to questions asked by members, Dr. Stewart said that his patient probably contracted the disease while working in the damp cellar three years ago. The patient was slightly worse now than when he commenced the faradic brush treatment.

Dr. BULLER here remarked that one eye was a little better, the other rather worse, than when first seen. The patient consulted him on account of failing vision. He found his sight much impaired. R. E. V., 20/100; L. E., 20/70, with great concentric limitation of the visual fields. The field for colors was constricted in a similar manner, but there was no central scotoma. The optic nerves presented the usual appearance of progressive atrophy from spinal sclerosis. The condition of the eyes, together with the absence of patellar reflex, seemed to warrant the diagnosis of *Locomotor Ataxia.*

DR. OSLER asked if the very early symptoms were preataxic, as it was well known that the eye symptoms often preceded for a long time lightning pains, etc.

Dr. R. P. Howard said that one of the first cases diagnosed in Montreal was one of his patients, who came to him suffering with transient strabismus, his walk was slightly axatic, but there were then no pains, he lived 15 or 16 years, and died in Europe last year. He had myosis.

Dr. Henry Howard remarked that he has had several cases under observation where impotency was the first symptom.

Dr. Osler, the past summer, had a patient under his care who had been troubled with double vision, and severe headache for four or five years. He went to London and consulted Dr. Broadbent, who diagnosed and treated him for cerebral syphilis. He got perfectly well, but two years ago Tabes began to develop, and now he is in the third stage of Locomotor Ataxia.

Dr. Ross said a patient came under his care yesterday in the Hospital, who had had the gait symptoms for two years, but till lately had had no eye symptoms at all. At present he is remarkably ataxic, has loss of patellar reflex, no lightning pains. Dr. Ross had asked Dr. Buller to examine this patient.

Dr. Buller remarked that the hospital patient with ataxic symptoms, sent to him by Dr. Ross for examination yesterday, had no loss of vision. His optic nerves, however, did not present a healthy appearance. They were somewhat swollen, and the margins decidedly indistinct, perhaps presenting the condition described by Dr. Gowers as gelatinous infiltration. The bulk of the papilla had a hyperæmic appearance, whilst the temporal side was in part rather unusually pale. On the whole, I think the condition was such as we usually meet with in persons whose vision is beginning to suffer from excessive use of tobacco and alcohol. With regard to the atrophy of the optic nerves met with in Locomotor Ataxia, Dr. Gowers has made the observation that when this condition comes on early in the course of the disease, that is, during the first or pre-ataxic stage, the resulting loss of vision is more rapid and more complete than when occuring as a later symptom ; this observation coincides with my own experience of such cases. When atrophy of the optic nerve occurs early it must, I think, often be a matter of doubt as to whether the trouble is of spinal origin at all. I know of several

cases in which atrophy of the nerves has led to complete blindness, which has now lasted for one, two, or three years without the development of any fresh spinal symptoms, though there has all along been absence of knee-jerk, yet all of these cases have been regarded as commencing Locomotor Ataxia by the very highest authorities on the subject, both in Europe and America.

Dr. R. P. Howard said he had three cases of Locomotor Ataxia at present. In two, there is great contraction of the pupils—one a gentleman, the other a lady. The gentleman has myosis of both eyes, but greater in one. In the third case the pupils differ, there is good vision in one eye. Dr. Howard remarked that a contracted pupil should make one look out for Tabes. There is great frequency of pulse in one gentleman and in the lady. The gentleman took Hyosciamin for a long time under Dr. Seguin, with but little effect. Dr. Howard said a late theory was that this disease was caused by functional excess of a sensory nerve, and that sexual excess was said to lead to it. Dr. Howard also remarked that out of many cases which he has seen, one only suffered from gastric crisis. Had used the electric brush in the case of the lady with the result of restoring feeling in some parts of the skin, otherwise no improvement followed.

Dr. Henry Howard had used the electric brush for anæsthesia with good effect where there was absence of motor paralysis.

Lawson Tait's Operation.—Dr. Armstrong exhibited the ovaries and tubes removed by him a couple of days previous from a lady, aged 22, who had suffered for three years from pelvic pain. She had menstruation for fourteen days for the past year, suffering much each time ; this quite unfitted her for work, and made life miserable. Both ovaries were prolapsed. Patient doing well. The ovaries were both a good deal enlarged.

Stated Meeting, December 28th, 1883.

T. A. Rodger, M.D., President, in the Chair.

Dr. Wood read a paper on the use of ether in obstetrics. His remarks were founded upon twenty-six cases where he had used ether instead of chloroform. Several cases were detailed at some length, and from the results of all he drew the following conclusions as to the relative merits, in his opinion, of ether and chloroform in obstetrics:—(1) Owing to the agreeable odor, early effects, and perfect safety of chloroform as an anodyne agent, it is without the least doubt the best agent to relieve pain and calm the nervous irritability incident to the first stage of labor. (2) This statement is generally true of the expulsive period, where complete abolition of pain is not the object of administration. (3) When, however, complete anæsthesia is required, as we find it necessary during the delivery of the child and for the performance of operations following or preceding delivery, then it is that chloroform largely loses its character as *the* obstetric anæsthetic, *par excellence*. Dr. Wood said that if considerations of safety must give way in general practice to greater convenience of administration, then in the operations of midwifery ether he thought must supplant chloroform. He alluded to the inflammable nature of ether and its explosive quality when mixed with a certain per centage of atmospheric air, as the operations of the obstetrician were generally at night; this was a serious objection to ether. Vomiting he thought as common with ether as chloroform.

Dr. Campbell said that during the past twenty years he had used anæsthetics very little; did not think it wise to give chloroform for hours, as some do; has noticed that the uterus does not regain its power as promptly when this is done. He saw an objection to ether in its smell and its being so irritating to the eyes. He believed the mental condition has much to do with the immunity from deaths with chloroform at this time.

The woman approaches the time for delivery without fear, knowing so many of her friends have safely passed over this trouble, whereas the person to be operated on by the surgeon has a dread often for a long time before.

Dr. Reed remarked that if there were no deaths recorded from chloroform during labor, then chloroform must be better than ether, as it has all the advantages without the objections. The statistics stood thus with regard to mortality—chloroform 1 in 3 thousand, ether 1 in 30 thousand, and gas 1 in 50 thousand.

Dr. Smith believes in easing a woman as much as possible, and has used and will use even for hours, if necessary, an anæsthetic composed of alcohol one, chloroform two, and ether three parts; had never seen flooding follow its use, and felt safe to allow a nurse to give it.

Dr. Trenholme only used chloroform during labor. With regard to the use of anæsthetics during labor, he is now more opposed than ever. When called to a woman, and finding the first pains irritable and the os thick and firm, instead of using an anæsthetic for hours he administers 45 minims of laudanum; this gives ease from pains, and they do not recur for a week or even a month, as often these are cases of false pains. Was sent for by a woman who said she had come to full term, but on examining found the above conditions present, gave her 45 m. laudanum; pains did not return for a month, when found her as before; gave another 45 m. laudanum—she went on for another month, when he was sent for again, and as the indications were present, wanted to give another dose, but the woman said she had carried the child for eleven months, and would not carry it a year for anyone. She was delivered two or three days later. He said that very tedious long labors left the woman more prone to post-partum hemorrhage, and remarked that the heart was more fatty during gestation, which would look as if anæsthetics ought to be dangerous in obstetrics.

Dr. H. Howard said that in his younger days anæsthetics were not known, and of course not used in midwifery cases, but

that in Ireland the pains of labor were often lessened by taking a good dose of whiskey punch ; he never saw harm come from it.

Dr. Campbell thought that Dr. Reed's statistics were not strictly true, as he believed there were cases in Montreal where the woman died from flooding due partly to the chloroform used.

Dr. Rodger had used anæsthetics largely always ; used chloroform till within a few years, and had seen post-partum hemorrhage follow its use. Now uses ether, but finds it not so useful as chloroform for irritable subjects in the first stages ; but for such cases he now gives a good dose of chloral. The great advantage ether has over chloroform is that you can dispense with an assistant in an instrument case, and feel perfectly easy while the nurse is giving the ether. In an instrument case before giving either anæsthetic he gives a dose of ergot to ensure good contraction.

Dr. Wood asked if any of the members had noticed whether their epileptics had anæsthetic spots.

Dr. H. Howard said that nearly all the epileptics with mania have anæsthetic areas over the body or limbs.

Mastitis treated with Ice.—Dr. Campbell mentioned a case of inflamed breast apparently on the way to suppuration, and beginning in the usual way with sore nipples, which he was treating with applications of ice. The breast, which was very much enlarged, is now terminating by resolution, and is only one-half its former size.

Dr. Trenholme said this was an old treatment ; that in most cases the inflammation begins in the lacteal sacs and that each opens at the nipple. Hot applications congest and increase the danger of its spreading to other cotyledons, but that ice isolates the inflammation.

Dr. Campbell related a case where he had confined a woman and left her well ; in three weeks he was sent for, as the baby was vomiting pus. On squeezing, pure pus came out of both nipples. The breasts were poulticed, and in 36 hours they looked like two bags of matter and discharged enormous quantities. He confined this same person lately, and now she nurses well from both breasts.

Dr. Trenholme reported that one of his cases of removal of both ovaries and tubes, operated on three and a half months ago, was now able to enjoy life thoroughly; she skates, and recently had walked seven miles.

Stated Meeting, Jan. 11th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Aneurism of Aorta—Rupture into left Bronchus.—Dr. Osler showed the specimen which was taken from a man aged about 50, who was admitted to hospital with shortness of breath, due apparently to bronchitis and emphysema. Attention was not particularly drawn to his condition. After a residence of three or four days in hospital, profuse hæmorrhage took place from the lungs and proved rapidly fatal.

The autopsy revealed the large aneurism of the ascending arch here shown. It projected beneath the sternum, the manubrium of which was eroded. Firm laminæ of fibrin occupied four-fifths of the sac. From the posterior wall of the transverse part of the arch two smaller sacs projected, the size of large walnuts; one of these had perforated the left bronchus and induced the fatal hæmorrhage. The heart was not hypertrophied. Aortic valves healthy. Interior of aorta atheromatous.

Aortic, Mitral and Tricuspid Valve Disease.—The heart showed extreme button-hole contraction of the mitral orifice with great thickening and induration of the mitral segments, adhesion of the aortic semilunar curtains with sclerosis, and great narrowing of the orifice and fusion, and thickening of the tricuspid valves, so that the orifice barely admitted the thumb. There was considerable hypertrophy of all the chambers, particularly the right ventricle. The patient, a woman, aged about 35, was brought to hospital with general anasarca and extreme dyspnœa, and died in 48 hours. No satisfactory history could be obtained, as she was a stranger, but she had had several previous attacks of dropsy.

Non-valvular Dilatation and Hypertrophy of the Heart.—Dr. Ross gave the following short history of the case: This

man, aged 48, had been under his care in the hospital for the past two years on and off, suffering from anasarca and at times with fluid in the pleura. He had a soft blowing mitral regurgitant murmur from his first admission; later on hypertrophy became evident, digitalis always relieved him. Two months ago he returned to the hospital and went through the usual stages of advanced mitral disease. He never had rheumatism or any of the usual causes of heart disease excepting that he was very intemperate.

Autopsy, by Dr. Osler.—A couple of quarts of serum in peritoneum, two or three pints in each pleura, and several ounces in the pericardium. Heart hypertrophied and dilated; thick yellow clots in right chambers. Weight of organ, 610 grammes. Valves normal; aortic segments competent; mitral segments a trifle thickened at edges; no vegetations. Mitral orifice over six inches in circumference; tricuspid orifice nearly seven. The chambers were much dilated, and there was moderate hypertrophy of the walls. Muscle of fair color. Apices of papillary muscles fibroid. Aorta smooth. Coronary arteries not atheromatous. Lungs showed moderate emphysema at anterior margins; general brown induration; a large infarct at base of right lung. No pleural adhesions. Cyanotic induration of spleen, which was double the normal size. Kidneys slightly enlarged, coarse and hard; three healing infarcts in the left. Catarrh of stomach and bowels. Liver undersized, a little granular in the surface, hard and firm, and in early stages of cirrhosis.

Dr. Osler remarked that this was the fifth or sixth case of the so-called idiopathic hypertrophy and dilatation of the heart which he had dissected. The question of ætiology was interesting and not yet settled. Most of these cases are in large powerfully built men accustomed to heavy muscular exertion, and Abbott, Myers, Leitz and others have regarded this as the chief factor. The condition of irritable heart described by Dacosta in young recruits may be supposed to be the initial stage of the process, although in the majority of instances the condition is transient. One point in connection with the etio-

logy must not be lost sight of, viz. : that in the great proportion of these cases the patients were hard drinkers, and how much the alcohol has had to do with the production of the disease is hard to say.

Dr. Trenholme asked if the condition of his liver would throw light on the primary cause. Dr. Osler, in reply, said he thought not, as it was not much diseased.

Dr. Kennedy said he knew of two somewhat similar cases. One was that of an athlete who has a mitral murmur, and whom he believes will develop, later on, symptoms like those just related by Dr. Ross. The second case was a young man who had sent for him, as he was suffering from weakness and sickness of the stomach. On examination, a soft mitral murmur was discovered. This young fellow, the day before, had gone for a very long snow-shoe tramp. Dr. Kennedy said we might expect to see similar cases more frequently, as snow-shoeing was becoming so fashionable.

Dr. Douglas had seen many cases of irritable heart in the army, but they never led to a post-mortem, as they would always be invalided. He said that Dr. Myers attributed heart trouble in soldiers to the pressure of the hook of the tunic on the vessels of the neck, increasing the labor of the heart, and producing palpitation.

Dr. Campbell said that cabmen, who at times have such heavy lifts, are prone to heart irritation. He knew of one well marked case. Has seen two or three cases in young men who, from over exertion at playing lacrosse, suffered from symptoms similar to those in Dr. Kennedy's cases. He (Dr. Campbell) had lately been examining a lot of young men about to enlist, and noticed that most of them came from occupations requiring very little muscle or heart work, as shoe and cigar makers.

Dr. Buller called attention to Dr. Richardson's experiments with men working with and without alcohol. Whilst abstaining they did a certain amount of work with ease ; the same men, allowed alcohol and doing the same work, suffered from palpitation and shortness of breath.

Pneumo-enteritis of the Hog.—Dr. Osler showed the colon from a case of this disease, known better by the names of hog cholera and pig-typhoid. A local outbreak in Hochelaga a few weeks ago furnished an opportunity of getting some interesting specimens. The disease is highly contagious, and the ravages in the United States probably exceed that of any other animal plague. The lesions are in the lungs and bowels—most commonly the latter, but the former may alone be involved. The specimen exhibited was a very typical example of the disease in the colon, the mucous membrane of which was converted into a thick greyish-yellow substance, owing to a sort of diphtheritic infiltration.

Dr. Alloway exhibited a *Fleshmole Placenta*, in the amniotic sac of which he found a small embryo (exhibited) mummified, which appeared to have been blighted at about the fifth or sixth week. The mole itself represented a mass about the size of a normal placenta at the fifth month. It had undergone fatty degeneration; its amniotic sac was filled with a dark-colored blood-clot, and contained the above-mentioned embryo. The history of the case was as follows: The patient, a young woman in her third pregnancy, had menstruated last in January, 1883. In March (two months afterwards), she received a severe fright, and had a slight flow of blood. From this occurrence she had no more discharge until the expulsion of a mole on 13th December following. During the months of February, March and April she had all the early symptoms of pregnancy; had noticed considerable increase in size, which continued until about June or July. She remained stationary in this respect for a short time, and towards the latter part she noticed herself reducing in size and the vagina giving exit to a muddy-brownish discharge (non-offensive). Dr. Alloway alluded to the interesting way in which these moles occur, and gave Scanzoni's views as follows: "The ovum remains with the dead fœtus for a considerable time in the uterine cavity; the coagulum (utero-decidual) undergoes certain changes, and so gives rise to the formation known as a *fleshmole*. The effused blood (utero-decidual) becomes decolorized by rupture of the blood corpuscles and absorption of their coloring

matter. The fibrin, Scanzoni supposes, becomes cellular tissue, and in this way is established a communication between the ovum and the uterine wall, which renders further development possible. The chief seat of this carneous degeneration is the decidua-vera. The amnion undergoes little change, and may be found adhering to the inner surface of the chorion, containing within its cavity a quantity of bloody fluid, and in which will be found what remains of the embryo." Dr. Alloway said his specimen corresponded to the description of a mole as given by Scanzoni; that he was sure the patient had become pregnant in, or before, March (nine months ago), and that the embryo had been retained in the amniotic sac in its mummified condition during that period. Dr. A. was also of opinion that many such cases occurred, but the embryo, not having been looked for, escaped in the discharge, and was thought to have been absorbed.

Dr. Geo. Ross said he had failed many times to find the embryo in an early abortion and had no doubt but they are often dissolved in utero.

Dr. Kennedy said that if there was any separation from the uterine wall then the embryo was rapidly dissolved. Had a case where the embryo was perfect; left it in the amniotic sac over night, but by the morning it was entirely dissolved. He (Dr. K.) did not believe that Dr. Alloway's embryo had been in the uterus very long, certainly not anything like what Dr. A. seemed to think. She might possibly have had one or more miscarriages early, but from the size of this specimen did not believe it was more than five or six weeks old. The relatively large size of the placental mass was due to its continuing to grow after the death of the fœtus.

Dr. Trenholme agreed with Drs. Ross and Kennedy.

Dr. Alloway, in reply, said he gave the Society the exact facts of the case, and wished the members to form their own opinion regarding the possibility of the embryo and membranous mass exhibited having been in the uterus for the length of time mentioned. In defence of the mass being what is known as a true mole, he gave Scanzoni's definition, which corresponded to his specimen. In reference to the black clot found in the

amniotic sac, it must have been recent, otherwise it would have undergone the changes explained by Scanzoni and which take place in extravasations in other parts of the body.

Dr. Alloway also exhibited a *small piece of decidua* (about one inch square), showing, on the inner side of it, a distinct lining of amnion. The history of the case from which he had removed the specimen with the dull curette was as follows :— Patient, a woman about 40 years of age, mother of 12 children, had been losing blood from the vagina for several days ; had been taking medicine from a physician, and had had her vaginal passage plugged daily to arrest hemorrhage. She was found by Dr. A. in a dying condition ; no pulse at wrist, surface completely blanched, and extremities cold. Could not obtain an answer to questions. Heart's action could be heard very faintly through chest walls. She had received the last rites of the church, and was, in fact, dying. Removed all the cloths and packing in vagina ; felt a fringe-like substance high up above the internal os, but could not reach further with finger. Passed up curette and detached the piece of decidua, and withdrew it with forceps. Washed out parts with antiseptic solution. Patient could not swallow. Administered hypodermic of ether. Ordered beef-tea, egg and brandy rectal injection every two hours ; heat to extremities and body generally. Patient improved by the morning, and gradually recovered life, but remains bloodless as when first seen, three weeks ago. Dr. Alloway said he adduced the case to show the great danger of following out rigidly the expectant plan of treatment in such cases. Efforts had evidently been made to remove the secundines with the finger, leaving behind the small portion exhibited, which was causing the hemorrhage. Those who opposed the curette were physicians who had never used the instrument, and had not convinced themselves of its perfect harmlessness and great value.

Dr. Trenholme said that a small piece of alum pushed into the os was what he found most useful for flooding in abortions.

Dr. Kennedy believed that interference was seldom needed ; that where the ovum was not entirely separated, it was best to plug and give ergot. Had several times known flooding to have been produced by meddling.

Dr. Rodger remarked that the physician first in charge of Dr. Alloway's case could not have plugged her properly, else she would not have been so low; believed the alum egg to be the most useful plug in such cases.

Elephantiasis of the Labia Minora and Clitoris—Operation—Death from Pyæmia three weeks later.—Dr. Gardner exhibited the specimen and gave the following particulars:—The patient, aged 45, came from the country with a history of syphilis for 13 or 14 years. Besides the above tumor, which was attached principally to the base of the clitoris, there was present stricture of the rectum and a recto-vaginal fistula. The orifice of the urethra was so large as to easily admit the finger into the bladder. Dr. G. amputated the tumor with a scalpel, dressing the wound with iodoform. The temperature rose next day and pyæmia developed; there was swelling and effusion into several of the joints, suppuration taking place in two of them. The pyæmia was caused probably by embolism of the veins of the part operated on, the fœtid ulcerations around supplying the septic matters. A post-mortem showed extensive ulceration of the rectum with a stricture only admitting a goose quill. A pus cavity was found in the left broad ligament, but there was no visceral suppuration. The tumor was about 4 or 5 inches long and nodulated.

Dr. Kennedy remarked that the operation was undoubtedly called for, but the result was unfortunate.

Dr. Alloway said he had a patient with a similar tumor which now measures 7 inches in length. It does not cause much trouble, being covered with good skin and kept wrapped in a napkin. It began when the lady was 10 years old and has been gradually increasing.

Stated Meeting, Jan. 25th, 1884.

T. A. Rodger, M.D., President, in the Chair

Case of triple birth at 7th month of gestation, in two of the fœtuses development had been arrested at about 4th month.—Dr. Beaumont Small, of Ottawa, sent down the above 4 months' fœtuses along with the following history and remarks :—

The patient was a young woman of delicate health who had always been anæmic and troubled with menorrhagia. During the first four months of married life the prolonged menstrual periods continued without change. She then became pregnant, her general condition improved, but she persisted in performing heavy household duties. During the early months of pregnancy there is no history of any condition likely to cause injury to the contents of the uterus. During the last month before delivery there were marked signs of irritability of the uterus. Slight disturbances, such as driving over a rough road and jumping easily from a buggy were followed by pains and distress much more severe than the causes would lead one to expect. About a week before delivery she fell upon her side receiving a severe shock, active pains ensued and continued until delivery. I was not able to find out if the membranes had been ruptured at the time of the injury. Upon my arrival labor was well advanced, the os fully dilated and waters discharged. During examination a loose body was detected projecting from the os which I endeavoured to recognise as an arm or leg. To my surprise it became loose and was easily withdrawn—proving to be fœtus No. 1, in a black, shrivelled, flattened state, differing very little from its present appearance. The flattening was due to compression between the head and pelvic walls. No placenta was attached. In a short time a well-nourished but lifeless fœtus of about seven months development was delivered : it had been dead for a day or two only. The placenta followed easily,

there was no sign of its being a double organ, or of any attachment of the other fœtus. Shortly after fœtus No. 3 was removed with its placenta attached. This placenta was elongated and evidently fœtus No. 1 had been joined to it. Convalescence progressed favorably and the patient regained her comparative good health. There is no instance of multiple births having occurred in her mother's family. The cause of this unusual condition, I think, can be traced to the impoverished physical condition of the patient. The burden proved too great for the enfeebled uterus—the single placenta proved the stronger and attracted the greater show of nutriment—the other was correspondingly weakened and ultimately destroyed. Such instances of the power of toleration possessed by the uterus are rare. At a recent meeting of the Obstetrical Society of London a similar condition was reported in a twin birth. One other member only had met with the same in his practice.

Dr. Kennedy had never seen a similar case. He thought that pressure stopping the circulation was the cause of death of the specimens exhibited.

Dr. Wm. H. Hingston read the following paper on *Certain Forms of Club Foot* :—It is precisely one hundred years since, as Adams says, the treatment of club foot was limited to mechanical appliances, when Thilenius proposed the division of the tendo-Achillis by an open wound ; sixty-eight years since the division of the same tendon subcutaneously was performed—if Delpech's operation deserves to be so designated ; and fifty-three years since Stromeyer improved upon the operation of Delpech by puncture and subcutaneous division. The modification of the operation of Thilenius, so far, concerned the manner of dealing with the tendo-Achillis, for to that tendon alone was imputed all the blame of the deformity, until comparatively recently, when other structures—tendinous, muscular, ligamentous, bony—have received attention. I intend here to speak only of that inveterate form of club foot ; not of that simple form with which all are familiar, and which the nurse's, and, later, the mother's hand alone may remedy ; nor of that other form which mechanical appliances may easily correct ; nor of the milder

form which tenotomy alone will cure; nor of a still severer form in which tenotomy of certain tendons, aided by mechanical appliances, suffices to remedy; but of that still severer form in which division of all the tendons and fascia commonly, or exceptionally at fault, followed by the use of the best mechanical contrivances, are powerless to remedy. One such case I exhibited to you last year, in the person of Emelie, aged 15 years, upon whom I had operated in the early part of 1881 for exaggerated talipes equino-varus. It may be in the recollection of some of you, that, when I showed to .this Society the young girl in question upon whom I had performed the operation which had been introduced to the profession by Dr. Phelps, of Chateauguay, N.Y., based on the principle enunciated by Dr. Post, of New York, in dealing with wry neck, I mentioned that I had already, with the tenotome, divided, without much amelioration of the deformity, all the muscles usually at fault in this affection. There remained, to undo the excessive arch and shortening and doubling-in of the foot, excision of a portion of the tarsal bones; but the additional shortening of the foot that would result, not to speak of the considerable risk to limb and life of opening into the inter-tarsal articulations, made me disinclined to resort to it. You saw the result of the operation in a completely straightened foot, without any diminution, but with increase of its length, and with but temporary impairment of its strength. The operation, so far as the members of this Society knew, was a novel one, and one not without the apparent qualifications of rashness.

I shall give short notes of a second, third and fourth, and two photographs of the last.

J. McG., æt. 19 years, the subject of exaggerated talipes equino-varus, entered the Hotel Dieu on 12th February, 1883. He had been born with the deformity, but, as years rolled on, the deformity had become greater. The heel was drawn up; the foot very strongly inverted, and bent inward upon itself. The patient walked on the outside of his foot; and the usual cutaneous and tarsal thickness existed there. I could not undo, in the slightest, this exaggerated deformity. I divided sub-

cutaneously the plantar fascia, tibialis posticus, and anticus, and the flexor pollicis and long flexor digitorum, and, lastly, *as is usual with me*, the tendo-Achillis. With the exception of bringing down the heel somewhat, the deformity, notwithstanding considerable force, was not relieved—the excessive arch remaining as before. I then adopted free open incision ; swept the knife across the sole of the foot, dividing tissue after tissue till the bones were reached. The excessive arch was then in great measure, but not completely, remedied. Across the ball of the foot a padded splint was applied, and on this, adhesive plaster to which were attached cords which led over pulleys, and a weight of 12 lbs. was suspended. With the exception of looking after the foot-piece, and sliding it nearer to, or farther from, the open wound, no surveillance was needed. The dressing consisted of vaseline for the first two days, and afterwards carbolic lotion or red wash, as suppuration was more or less abundant. When the patient left the hospital, on 30th April, his foot was quite straight and supported his weight comfortably. I have since learned that the foot is in every respect like the other.

Case III.—Is that of a boy, J. D., aged 10 years, who entered the Hotel Dieu under my care on 15th October, 1883, for double congenital talipes equino-varus. The deformity in both feet, but chiefly in the left, was excessive, and no amount of force, even under chloroform, could diminish it. Subcutaneous division of the supposed faulty tendons of the left foot was performed, and in the order named in previous case ; but, apart from giving greater freedom to the heel on the division of the tendo-Achillis, the rigidity and deformity remained. I then used the scalpel very freely to the sole of the foot, dividing all the tissues down to the bone, and gradually unfolded the excessive arch. This added most markedly to the length of the foot —the cut edges at their centre gaping apart to the extent of nearly two inches. I had difficulty in keeping up extension. The boy was a mischievous fellow, difficult to control. Pulleys were ineffectual, as they were tampered with either by himself or some other patient. But what was found to restrain him

effectually was a quickly-setting plaster-Paris splint, with a fenestra opposite to the incision. Through this the gaping wound was filled with tow soaked in Peruvian Balsam and renewed once a day. Granulation went on with surprising rapidity to the end. (I may here say, by way of parenthesis, that Peruvian Balsam, used in this way, is, without exception, the best application with which I am acquainted, and fully merits the favor in which it is held by Sayre and others.)

Case IV.—This subject was the same as the preceding, the foot this time being the right one. As the deformity was not so great as in the left I hoped, by free subcutaneous division, to remedy it in great measure; but the relief obtained by tenotomy was so inconsiderable that I proceeded at once to treat it as I had treated the left. The order of division was as in preceding case, with this difference, that structures already divided subcutaneously required no further attention by the open wound. The great difficulty in the treatment of the second foot, as in the first, was to keep up proper extension. Every additional day in the hospital added to the boy's cunning and to his desire to display it, regardless of consequences, to the admiring patients around him. During my absence of a couple of days from the city the boy manipulated things as he wished; and on my return, finding the old state of things partially restored, I put him again under chloroform and forcibly extended the foot. This forcible tearing open of a partially healed wound, I may add, was followed by more suffering than was the original operation.

In talipes equino-varus, however exaggerated the degree, there is, there can be, no contraction of either the abductor or of the short flexor of the little toe. The plantar fascia is almost always at fault, and its division remedies to some extent the deformity. The division of the flexor brevis muscle still further relieves the tension; the separation of the flexor longus digitorum still further; division of the tendon of the flexor longus pollicis still more markedly; and that of the flexor accessorius still further. The lumbricales, as they are on the

phalangeal side of the incision, escape division—while division of the tendon of the tibialis posticus completes in a satisfactory manner the relief of the deformity, unless, as in Case I., the long calcaneo-cuboid ligament, a much longer ligament than its name implies, be also partially severed. The hemorrhage is not what might *a priori* be expected. The internal plantar artery, 'tis true, is divided; but the external plantar, much larger than the internal, escapes division, if the knife be not needlessly carried beyond, or in front of, the base of the fifth metatarsal bone. Leaving the large external plantar untouched, its numerous distributing branches suffice to keep the muscles, and the digits and their appendages, abundantly supplied with blood. In no case was the temperature of the foot on the distal side of the incision lowered, and granulations sprang up as abundantly on that as on the central side. The internal plantar nerve is divided early in the operation; and, if the incision be carried too far back, the external plantar suffers also; but this would be unwarrantable. Respect for the arteries prevents our carrying the incision too far forward; and respect for the nerve too far backward.

A question will now obviously suggest itself: Why not divide all these muscular structures subcutaneously? And in the answer to which lies the gist of the whole question: the skin itself is largely at fault, and must be divided; and the division of the artery necessitates an open wound. In Case II. every muscle and tendon were divided down to the bone, but the relief was not what I expected till the unfolding process had gone on for several days after division. In the third and fourth cases (those of the young boy) I was disheartened at the imp's devices with the aid of other patients in the ward to relieve his foot of restraint. The weight and pulley were not equal to him.

The quickly-setting plaster, to which a little salt had been added, applied under strong extension, suited admirably in one foot; and in the other a simple and inexpensive device, suggested to me by Dr. Phelps, and which I now show to you, was used with satisfaction. Most of you are familiar with the method of

applying adhesive plaster around the foot, and along the outer side of the leg; but in this plan the plaster so applied is divided between its two attachments on foot and leg, and two pieces of thick wire, like telegraph wire, and made into hooks or two buckles, are attached, and these are drawn together with strings and tightened as the plaster loosens This device is a simple, inexpensive and efficient one, and is much better than the single piece of adhesive plaster which, when it slips, becomes useless.

What is 1st, the position of the operation; and what are, 2nd, the limits of its application? It is a most useful one, and one which, compared with excision of a wedge-shaped portion of the scaphoid—an operation which hitherto has not met with any considerable favor—is simple, safe, and requires no dexterity whatever in its performance.

What are the limits of its application? These appear to me clearly defined: 1st. Eliminate all cases in which, by hand or by mechanical appliances, or by both, deformity can be relieved. 2nd. Eliminate all cases which can be relieved by tenotomy. 3rd. Eliminate all cases where these, or any of these methods, or all combined, may suffice; for in all those cases would the operation by open division be totally unwarrantable.

But in those cases of exaggerated club foot, as these now submitted, with excessive arching and shortening, and more especially with narrowing and rolling in of the foot upon itself, *which cannot be relieved by the usual methods*, operation by open division offers important advantages.

CASE IV.

(*Before the operation.*)

(*After the operation.*)

Dr. Shepherd said that Dr. Hingston ought to be congratulated on the results obtained in the cases just quoted, and spoke of the success which Dr. Davies has in these cases, where he operates by removing a wedge-shaped piece from the scaphoid bone.

Dr. Hy. Howard asked Dr. Hingston if the wedge-shaped opening which fills with granulation tissue ever contracted later on, as he had seen operations on the eyelids, which, after healing, were perfect, become a source of trouble from contraction of the granulation tissue months after. In one of these cases, that of a lad, it became necessary to perform a rhinoplastic operation. A bit of the cheek was transferred to the upper lid, and, later on, whisker hairs grew from this piece.

Dr. Hingston said that in the face this was so—the tissue would contract; but in the foot, which, with each step, was stretched, this would not occur. In the girl operated on two years ago, there is no contraction.

Dr. Wood exhibited two *Albinos*, and gave the following particulars:—Two boys, aged respectively 9 and 6, with congenital nystagmus, the elder having also right convergent strabismus. They are both albinotic—white hair, eyebrows, skin, and choroid; also pink irides. The eyes are very sensitive to light, and the children are both myopic. They are now, and have always been, healthy. There is no other instance of albinism in family or in any of parental relatives. No parental consanguinity or chronic neurotic disease. Other children healthy; none dead. The children are perfectly intelligent, and the elder has learned to read, although he suffers from inability to bring about proper ocular fixation. The elder child has fair distant vision, though they both suffer from amblyopia. Excitement of any kind increases the oscillation of eyeballs. On examination by ordinary light, the interior of eye can readily be made out. The mother had nothing to say regarding prenatal impressions of any sort. There are four children in family, and these are second and third. Dr. Wood said the question was, how should their eyes be treated?

Dr. Kennedy thought colored glasses, by absorbing some light, would be useful.

Dr. Hy. Howard had seen several similar cases. He used to treat them successfully by using ordinary colored glasses covered with chamois leather, leaving a slit-like opening in the middle of the leather.

Double Nipple.—Dr. Campbell mentioned having lately seen a man with two nipples on his left side, and said that Dr. Howard of Lachine had recently seen a case of double nipple on each breast.

Dr. Smith had seen a similar condition in a woman.

Traumatic Delirium.—Dr. Hingston mentioned that lately he had had an unusual complication follow several operations, viz., violent delirium, with high temperature, lasting four or five days, but never ending fatally. Some of these cases occurred in private practice, others in hospital, and all in temperate patients. He asked if any of the members had similar cases.

Dr. Trenholme said he had seen several cases of high temperature, accompanied with delirium, follow delivery at the Western Female Hospital.

Condolence.—The following resolutions of condolence were passed :—

Resolved,—That the members of this Society have heard with deep regret of the death of Dr. John Reddy of this city, which took place in Dublin on the 23rd January. The Medico-Chirurgical Society of Montreal feels that in the death of Dr. Reddy, one of its former Presidents, it has lost a member of the profession who, in his entire work, proved himself to be devoted to its best interests.

Resolved,—That this Society extends to the family of the deceased its deep sympathy in the bereavement which has befallen them.

Stated Meeting, Feb. 15th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Dr. Osler exhibited the following pathological specimens:—

1. *Portions of Muscle, Intestine and Kidney from a Horse dying of Toxic Hæmoglobinuria or Azoturia.*—Dr. Osler mentioned that this disease was rather common here, and that usually the animals recovered. The disease generally attacks well-fed, well-cared horses which have been kept in the stable for a few days and then put to work again. The horse, while in the stable and on taking him out, appears perfectly well, but after an hour or two's work becomes weak, trembles and falls, and may die in 24 hours. The muscle shown was from the gluteal region, which is the part most affected. It had a parboiled appearance, was pale, and much infiltrated with serum. The intestines were deeply congested. The kidneys were somewhat swollen, soft, and congested. On section, the Malpighian tufts and cortical portion were seen to be engorged. Microscopically, the muscles had a teased appearance, with the striæ almost obliterated. The kidneys showed the Malpighian tufts to be congested. The epithelial cells of the tubules were filled with granular matter. The urine drawn by catheter was coffee-colored, and contained albumen and large granular tube casts. This disease is thought by Williams and Fleming to be caused by an excess of nitrogenous matters in the blood, though the pathology is not at all clear.

Dr. Ross said it was very remarkable to see such advanced tissue changes produced in so short a time, and asked Dr. Osler if the disease might not have been latent, and suddenly, from some outside cause, develop somewhat in the same way as does acute inflammatory nephritis in a child recovering from scarlet fever. The child, though appearing well, is really not so, for a slight cold may suddenly light up the latent kidney trouble.

Dr. Osler thought that possibly Dr. Ross' theory might help to clear up some of the difficulties

2. *Organized Thrombus of Left Iliac Vein.*—This specimen was solid and firm, with absence of coloring matter of the blood. Dr. Osler remarked how variable was the time taken to organize a thrombus. Here it took only three days to be as far advanced as in other cases of ten or even fourteen days' duration.

3. *Dermoid Cyst of Ovary containing sebum, hair and teeth.* —This specimen, about the size of two closed fists, was removed by Dr. Fenwick, and contained five teeth, one of which, attached to a piece of bone, was a well-formed incisor.

4. *Rapidly-formed Scirrhus of the Liver, with Tumor at side of the neck.*—The above was removed post-mortem from a man sent to the hospital from Ottawa. He came to have the tumor in the neck removed. On admission, no abdominal trouble was noticed or suspected. The tumor in the neck was situated in the upper triangle, moveable, and had been growing six or eight months. It felt as if it could easily and safely be removed, but symptoms of difficulty in swallowing and alteration of voice pointed to implication of the pneumogastric nerve, so that the case was watched for a few days, when it was observed that the liver was enlarged. The man said he had been growing larger for about three weeks. He had been a hard drinker. From the rapidity of growth and absence of jaundice, Dr. Shepherd diagnosed cancer, and had him transferred to the medical side, under Dr. Ross. On dissecting out the neck tumor, which was about the size of one's fist, Dr. Shepherd found it attached to the deep blood-vessels and nerves, the pneumogastric being deeply involved, and some of its strands separated. The liver weighed nearly nine pounds; on its under surface was a huge, isolated mass, with secondary nodules around.

Dr. Osler said that both tumors were scirrhus, and that it was hard to say which was the primary.

Dr. Shepherd thought the one in the neck must be, from the fact that it had been growing so much longer.

Dr. Ross said that this growth in the liver was the fastest he

had ever seen ; every forty-eight hours would show a noticeable increase in size. The man never had pain till ten or twelve days before his death, when he had some inflammation of the peritoneum.

Sarcomatous Tumor removed from the Thigh.—Dr. Perrigo exhibited the above, which he had removed from a lady aged 38, the mother of six children. It was attached to the periosteum, below and a little behind the great trochanter, extending under the gluteus maximus, and completely filling the hollow between the trochanter and tuber ischii. It did not involve the muscles, but simply displaced them. It rested upon the sciatic nerve. The patient first consulted Dr. Perrigo, about two years ago, for sciatica, and about one year ago he detected a tumor about the size of an egg, and freely moveable. It increased in size steadily, and during the past three months very rapidly. Four or five years ago this lady had had an attack of phlegmasia dolens, from which she made a tardy recovery. The tumor was about six inches long by four thick. A recurrence is looked for.

Puerperal Fever.—Dr. Alloway read a paper* on this subject, in which he strongly advocated the use of suppositories containing 10 grains each of iodoform and boracic acid, made by pressure, with cocoa butter. As a prophylactic vaginal antiseptic injection for normal labors, he recommends a solution of Hydrarg. Bichlor., $\frac{1}{2000}$ strength. He laid stress on the fact that the syringe used must be a new one.

Dr. Kennedy said he had seen a very large number of cases of puerperal fever ; he had had three outbreaks of the disease in the lying-in department of the Western Hospital, and a great many in the practice of his *confrères*. In the hospital, he had noticed how easy it was for the disease to originate, and was struck with differences in the temperatures according to the nurse on duty. With some nurses the temperature ran high, but with others very little change would be observed, and he believed that strict antiseptic precautions were more necessary with obstetric cases than in surgical operations. In the first

* See March (1884) number Can. Med. & Surg. Journal.

outbreak in hospital, it spread from a private patient attended by a physician who at the time was in close attendance on a case of puerperal fever outside. He stated that most of the modern authorities on obstetrics grouped under the heading of puerperal fever all the different conditions which might arise during the puerperal state; but, personally, he did not think it proper to look upon a pelvic cellulitis, inflammation of the uterus, or a phlegmasia dolens, as more than being coincident with the fever, although it was thought by some that these conditions were alternatives of the disorder. Some years ago a paper was published in an English periodical giving three forms of the affection. First, the pyæmic; next, auto-infection; and, thirdly, by contagion. He believed that this division was the best, and agreed fully with his own observation. The pyæmic form was rare, and that by contagion also less frequent than by auto-infection,—the latter form comprising by far the greater number of cases he had seen. As for the general treatment of these cases, it must be chiefly preventive, and he had found good results from Dr. Goodell's plan of placing the patient upon quinine in combination with an acid, and adding either morphia, ergot or digitalis, as may be indicated. During the presence of the fever, he had found turpentine in 10-drop doses every four hours to be of great value. For the local treatment, every case would require to be treated according to the coexisting complication. As for iodoform, this had been used in the Western Hospital for over three years, being introduced into the uterus whenever the discharge from that organ was offensive; and as the majority of cases in hospital were primipara, vaginal lacerations were frequent, and in these it was the constant practice to introduce iodoform suppositories after each injection. For the injection, he at first used carbolic acid, but although this was more cleanly, the permanganate of potash, was now preferred on account of its more powerful action in purifying the discharges and in destroying septic germs. Of the induction of puerperal fever by zymotic disease, he would mention a case which occurred in hospital. A yonng girl, who had been an inmate for some time awaiting her expected confinement, was allowed to visit her friends, at whose

home there were sick children. A fortnight afterwards she was taken with labor pains and delivered naturally. At the time her temperature was noticed to be 103°F. As puerperal fever was suspected, she was isolated. The following day the bright rash of scarlet fever covered her entire body, and the nature of the disease thereby indicated. Death ensued ; and in this case there could be no doubt of its cause, which could not be true puerperal fever, as it manifested the high febrile state before the labor, which latter was somewhat premature and a consequence. In connection with this subject, he would draw attention to that condition which was known as milk fever, the weed or ephemeral fever. Very little mention was made of this disturbance by the later obstetric authorities, but a separate chapter would be found in Churchill. As he had known some of his younger *confrères* to mistake it for puerperal fever, he thought more attention should be directed to it. Formerly it was more common, and its rarity now must be ascribed to the better diet prescribed, and also to the child being suckled soon after birth, not waiting until the breasts became gorged with milk, as was the old practice. In hospital, the few cases which had occurred were in badly fed women, and had given an opportunity to students to diagnose between the two conditions. These cases were always marked by the violence of the chills, which commenced between the shoulders. In septic forms, the chill spread from the extremities. This difference was strongly diagnostic ; and as ephemeral fever ran its course in from 24 to 48 hours, marked by profuse sweating and high temperature, it was often treated by a placebo so as to allow the case to run its course for illustration. Generally Aconite and Ammon. Acet. was given. He had no doubt that such cases were often mistaken for puerperal fever, and treated by large doses of quinine, the subsequent rapid termination of the case being ascribed to the influence of the quinine. In puerperal fever, he had no faith in the large doses of quinine usually given, not having seen any beneficial results from their use.

Dr. Trenholme said his experience with puerperal fever was limited to consultations with others, having never had a case in

his own practice. He believed each case ought to be treated, not by any rule, but separately. He also spoke against the common method of twisting the placenta for removal of the membranes, believing that it often breaks inside, enclosing a small clot of blood, which would do mischief by decomposing. He advocated Dr. Goodell's rule of getting the patient to walk from the bed on which she had been confined to her own room, and also of allowing her to sit up each day for a short time to favor drainage.

Dr. Gardner remarked that while he admitted the great value of intra-uterine antiseptic injections, and of intra-uterine use of iodoform in the manner recommended by the reader of the paper, it could only be useful in forms of puerperal poisoning by absorption of septic stuff from the decomposition of matters contained in the uterus—the sapræmia of Matthews Duncan; the ichor-apræmia of others. He believed with Dr. Robert Barnes* in the existence of another form of puerperal blood-poisoning, with fever, due to failure of the lymphatic system and liver to modify the waste stuff thrown into the circulation from the disintegrating uterus and appendages, and to failure of the excretory organs—the lungs, kidneys and skin—to remove from the system that same waste-stuff. In such a form of fever, he could not see how such remedies could have any effect. Their utility must always be limited. With reference to the mode of intra-uterine injection, he had had recently a case of enucleation of a large sloughing sessile myoma, in which the after-treatment consisted in retaining within the uterus for a fortnight a double drainage-tube, through which irrigation, at times continuously, and again intermittently, was practised, which suggested to him that this might, in some puerperal cases, be the best method of securing drainage and of irrigation of the cavity of the uterus. The conditions, it is true, are not exactly similar. In both there is a raw surface on the interior of the uterus, but in one there is superadded the importantly complicating blood conditions from the presence of waste-stuff from the disintegrating uterus. In

* *Amer. Jour. Obstet.*, vol. xv., page 53.

the case of the myoma alluded to, the antipyretic effect of the irrigations was most marked several times in the course of the after-treatment.

Dr. Kennedy mentioned having recently to treat an unusual accident, viz., dislocation of the head of the humerus, with fracture of the coracoid process of the scapula.

Dr. Shepherd made a few remarks on the difficulty of diagnosing such cases.

Stated Meeting, February 29th, 1884.

Wm. Osler, M.D., 2nd Vice-President, in the Chair.

Unilateral Hyperidrosis and Tabes Dorsalis in a Female — Dr. Reed read the following notes of this case:—

Mrs. L., aged 39, married seven years; has had one child, six years ago, which only lived a few days. In July, 1883, after a long walk, was surprised to find a copious perspiration on the right side of the face and head. Previous to this time she had a dry skin and did not sweat. She now finds that with active exercise, or with the warmth of the bed at night, or with nervous excitement as by fright, her hair on the right side of the head becomes wet, while beads of sweat appear on the face, throat and neck, limited to the right side. Simultaneously with the breaking out of the perspiration, the right cheek and ear become red and perceptibly hotter than the left. There is considerable injection of the conjunctiva at that time, and lachrymation is easily excited in the right eye at all times. The pupil of the same eye is constantly dilated; both pupils respond but very slightly to the stimulus of light. There is some tenderness, on deep pressure, at the middle of the right sterno-mastoid muscle. Chronic inflammation of the right cervical sympathetic is presumed. If this nerve is at fault, the symptoms in the case indicate, that while the vaso-motor fibres are in a state of paralysis, the pupillary fibres are in a state of irritation.* The patient

* *Vide* Eulenburg and Guttmann on Sympathetic, trans. by Napier, fol. 58, for a similar case.

appears in good health, but is short.minded, and has at times a voracious appetite. Pulse feebly felt in both wrists, 85 standing. Urine very pale, free from glucose and albumen.

Tabetic Symptoms—Has had fulgurant pains in spots in the legs. When asked about her feet, said she had noticed them to be " asleep " sometimes, and had found her gait at times awkward, so that she has stumbled ; once she fell on the sidewalk, cutting her lip. The toes seemed to droop. Knee jerk absent. Stands well with eyes closed. No ataxia of legs ; no numbness noted. Syphilis cannot be positively excluded.

Has one sister living. Father and mother died at an advanced age. Nothing known of neurotic disease in the family history.

I am indebted to Dr. Buller for having made a careful examination of the eyes ; he reports nothing diagnostic in the fundus. The right pupil measures $4\frac{1}{2}$ mm. and the left $2\frac{1}{2}$ mm. in the shade ; accommodation good. Right lens has a few small pigment spots, suggestive of former slight iritis, and is a little turbid, indicating incipient cataract. Optic nerves slightly pale, but probably not exceeding physiological limits. Field of vision not impaired ; color sense perfect.

The diagnosis of tabes dorsalis depends on the Argyll-Robertson pupils, fulgurant pains, and absence of knee-jerk. There is no evidence of neoplasm or aneurism in the neck or thorax to account for the hyperidrosis. The case is noticeable on account of the rarity of tabes in females in this country. No satisfactory reason has been given, as yet, for the great comparative exemption of the female sex. Neurologists of vast experience, such as Weir Mitchell of Philadelphia and Buzzard of London, refer only to three cases each.

Dr. Hy. Howard said that unilateral hyperidrosis is by no means uncommon in cases of mania in the chronic stage, particularly where there is partial sensory and motor paralysis. It is just what we should look for in these cases, if we bear in mind the experiments of Dr. Isaac Ott, from which he drew the following conclusions :—1, That the sensory fibres decussate in part in the spinal cord ; 2, That the vaso-motor fibres also do ; 3, That the sudorific fibres follow the vaso-motor and decussate ;

4, That vaso-motors run in the lateral columns. Now, seeing that in nearly all cases of mania, particularly in the chronic stage, there is found some abnormal state of the different nerves, producing low temperature, etc., it is but natural that we should find hyperidrosis in these cases; but in the case brought under our notice by Dr. Reed, as yet there has been no pathological psychosis. But with the hyperidrosis, there is absence of patellary reflex, showing some abnormal or degenerate state of the sensory or motor tracts in the cords, with enlarged and fixed pupil, showing a partially paralyzed state of the ciliary nerves. With these symptoms, I should say that there was some abnormal state of the spinal cord, or of the vaso-motor, sudorific and sensory nerves in their course along the sides of the cord, which time will more fully develop.

Dr. Osler had seen two cases of unilateral hyperidrosis during the past two years, one of which was in a patient suffering from caries of the cervical vertebræ.

Dr. Reed remarked that he, with Dr. R. P. Howard, was treating another case of tabes in a female.

PATHOLOGICAL SPECIMENS.

Actinomykosis.—Dr. Osler exhibited the jaw of a cow attacked by the above disease, often called "big-jaw," or osteo sarcosis, and due to a fungus, slides of which were also shown. The yellow color in the centre of the nodular masses was well seen. Dr. Osler said that this disease was fairly common in Europe and America, and has been known for a long time under a variety of names, such as tubercular stomatitis, scirrhus tongue, scrofula, etc. The tongue, lips and mucus membrane of the nose are often attacked. Actinomykosis is fatal unless removed with the knife. This disease is seen in the horse and swine, and even in man, twenty cases being reported, all in Germany. In man, multiple abscesses are generally produced throughout the whole body, a fatal issue always following.

Lack of Development in an Infant.—Dr. Trenholme exhibited the above, which was born at full time in the Western Hospital. There was entire absence of the genital organs and

pelvic bones. The abdominal wall was formed by the posterior wall of the bladder, on each side of which the ureters opened. The anus was covered with integument. The child lived four or five days.

Local Paralysis Agitans.—Dr. McConnell exhibited this patient and read the following history :—Fred. R., aged 34, was born in Cambridge, England. Since 20 years of age, has been occupied as a railway engineer. Has always enjoyed good health, and he is not aware of any member of his family having suffered from any nervous affection. On 20th August, 1882, at Sacramento, California, his engine collided with that of another train, and he was thrown violently to the ground, falling on the top of his head. He was quite unconscious for ten weeks. He received a scalp wound on the top of the head, at which point there can now be felt a distinct depression. On returning to consciousness, he found his head done up in a kind of harness, which he soon after ascertained was intended to prevent an involuntary lateral and continuous motion of the head. He was treated in California and in various cities throughout the United States. He states that all kinds of treatment have been employed, such as blisters, actual cautery, electricity, trained exercise, &c., and endless medication, with no relief to the movements. *Present condition*—Is somewhat emaciated ; very tall (6 feet 3 inches), and of light build, and appears very intelligent, speaking of his affection and the various methods of treatment in a humorous strain. There is a continuous rotation of his head from side to side—very regular when quiet, but increasing in frequency when he attempts to speak or perform any act, and ceases during sleep. When quiet, the movements are 103 times per minute. Frequently complains of pain over region of left temple. Has occasionally a slight discharge from left ear ; for some time after the accident this was continuous. Is usually very restless during sleep, talking much and tossing about. Walks well, except when he has attacks of what, from his description, appears to be vertigo, accompanied with double vision ; says sometimes single objects appear as if there were four. When one of these attacks occur, he usually has three or four in succession, occurring daily

or every other day, thus a month or two might elapse before again experiencing any. They usually come on suddenly while walking, when he is unable to guide himself, and has frequently been locked up, his condition being mistaken for drunkenness. There are no symptoms of paralysis, as loss of sensation From the symptoms of this case, I have looked upon it as one of local paralysis agitans, possibly symptomatic.

Dr. Ross referred to the article in Ziemssen's Encyclopædia on cases of clonic spasm. The writer there says that cases similar to this one of Dr. McConnell's are generally produced by blows on the back of the neck or head ; the operation recommended being to divide the spinal accessory nerve or excise a portion. The prognosis is bad.

Dr. Trenholme did not think it ought to be called paralysis agitans, and would suggest trephining over the depression.

Dr. Foley had seen nerve-stretching performed for a similar condition.

Dr. Osler said the symptoms were not unlike those seen after removal of the vertical semicircular canals in pigeons.

In reply to Dr. Trenholme, Dr. McConnell said : If not paralysis agitans, what is it ? According to the classification of the narration of the disease by Sanders in Reynold's System of Medicine, I certainly think it must come under that title. In regard to the suggestion made of trephining the skull at the point where the depression exists, with a view of curing the case, I think that result would hardly be attained. The movement is produced by alternate contractions of the sterno-cleido mastoid muscles, thus indicating some implication of the nervous structures at the origin of the spinal accessorius. I therefore think it a question whether treating the surface of the brain would have much effect on an apparently localized lesion in the upper end of the cord. In reply to Dr. Osler that it would be better classed as a case of multiple sclerosis, I may say that the fact of the affection occurring in one at his age, and being confined to the head, would favor that view ; but, on the other hand, the definite movements occurring during rest, as well as during voluntary movements, and the fact that no paralysis exists as

yet, although the tremor has lasted now a year and a half, are points which are generally supposed never to obtain in multiple sclerosis.

Stated Meeting, March 14th, 1884.

T. A. Rodger, M.D., President, in the Chair.

A groom sent by Dr. Gurd was exhibited to shew what appeared to be a clear case of accidental inoculation of horse pock in the human subject. A dark colored scab, depressed in the centre, was to be seen a little below the outer corner of the left eye and the parts about, were red and swollen. One of the horses which he had the care of was suffering from horse pock, so prevalent in the city lately.

Dr. Proudfoot shewed a specimen of epithelioma of the lower eyelid removed by him a few days ago.

Dr. Kennedy exhibited a small *Anencephalic Fœtus*, the deficiency also extending as a spina bifida downwards to the middle of the dorsal region. There are also an abdominal hernia, the protrusion being covered with the peritoneum only. At birth there was evidence that general peritonitis had existed for some time which no doubt had caused the death of the fœtus some days before delivery. The case was of some interest owing to the difficulty that arose during delivery. Dr. Kennedy gave the following history: The mother had passed through several pregnancies. Her first child was carried to full term, but the labour was difficult and only completed by instrumental delivery. Each successive labour terminated at the seventh month without any apparent cause, none of the children surviving. She came under my attendance with this last pregnancy, and at the time of engaging my attendance for her confinement, stated that a physician who had examined her had found an extensive laceration of the womb. No opportunity was given me of verifying this condition. Anticipating a recurrence of premature labour, rest and other precautions were taken to avoid its induction but without avail. I was sent for about the seventh

month and found she had been in labour about twelve hours. On examination of the abdomen the fœtal body was felt to be lying in an oblique position relative to the mother's body. A vaginal examination showed the os to be fully dilated and a large amniotic sac distending the vagina. As no movements had been felt for some time by the patient and there being occasional discharges of blood, the membranes were ruptured. An immense quantity of amniotic fluid came away, followed by a free discharge of blood. Failing to find any part of the chlid presenting, and as the loss of blood was becoming serious, the hand was passed into the vagina. The intention was to perform version at once, but owing to the pain it was thought best to retain the hand in the vagina as a plug to prevent loss and send for assistance. While waiting the placenta and cord were forced down into the palm of the hand, showing that the attachment of the placenta had been very low and that easy separation had taken place. Dr. Perrigo arriving, gave her chloroform. The hand was introduced into the uterus, which was found constricted in the middle. Dilatation of this constriction was slowly effected, and in the cavity above the fœtus was found and brought down by the feet. Delivery was speedily effected, the patient making a splendid recovery. This patient would, without doubt, have died from hemorrhage but for the promptness of assistance given her. The low attachment of the placenta may in some measure account for the deficient development of the fœtus.

Dr. Trenholme stated that in cases of lacerated cervix uteri the cause of abortion was not due so much to the laceration itself as to the diseased condition of organ induced by the lesion. The uterus was irritable and the altered state of the tissues hindered its normal development. The mere fact of lack of support was not enough to induce abortion, or we would meet with such more frequently than we do in multipara where, as is well known, a considerably dilated os was compatible with normal gestation. The reflected decidua effectually closed the womb, whether the os was lacerated or patulous as already stated.

Dr. Hy. Howard considered that there must always be a physical cause for a physical effect, and said it was the duty of scientific medical men to get at the cause of such deformities. He related a case in his own family of port wine mark due to a maternal impression.

Dr. Trenholme avowed his belief in the transmission of maternal impressions to the fœtus.

Dr. Proudfoot reported the case of a child born with one arm and one leg.

Dr. Wilkins remarked that Paget reports a case of a child with deficient fingers, apparently due to the mother having handled a deformed hand during pregnancy.

Dr. Geo. Ross thought that only cases of irregularity were the remembered ones. He also reported a case of hydrocephalic fœtus with fusion of the fingers and toes.

Dr. Trenholme exhibited two *Dermoid Cysts*, each attached to an ovary which he had removed on Saturday last. The left weighed two pounds and the right one pound. Both fallopian tubes were considerably dilated. The uterus, removed *post-mortem* and normal in appearance, was also shewn. The woman was aged 32, healthy, &c. Had suffered for many years, but especially since birth of last child, 5 years ago. Of late was unfit for duties of life and sought relief. Temperature and pulse continued most favorable for the first 24 hours, when pulse rose to 150, notwithstanding drop doses of veratrum viride, which was continued 8 or 10 hours. Twenty minims of Battley were given hypodermically in the evening to quiet the utterances of patient. She passed a quiet night and gradually sank, and died 44 hours after operation. Autopsy shewed limited but insignificant local peritonitis and some slight effusion. Heart was normal. The womb had healed by first intention throughout. The cause of death, while not clear, may be perhaps fairly laid to the veratrum viride, which may have caused the otherwise unaccountable collapse and death.

Dr. Kennedy remarked that he had seen two patients who seemed to have been affected injuriously by veratrum viride, and objected to its use in a case like this of Dr. Trenholme's.

Dr. Rodger had observed great rapidity of pulse follow the use of veratrum viride.

Dr. Stewart said that cardiac depressants as veratrum viride are contraindicated in puerperal cases.

Dr. Ross related cases of great depression produced by veratrum viride in the Montreal General Hospital. Convalleria seemed also to have acted unfavorably in a recent case treated there.

Dr. MacDonnell exhibited photos of a patient the subject of an internal tumor. The cutaneous abdominal veins appeared excessively enlarged.

Slow Pulse.—Dr. Mignault related a case of slow pulse in a dyspeptic—treatment brought the beats from 38-48 to 70.

Dr. Wilkins met with two cases where the rate per minute was only 45.

Dr. Stewart had a case of 25 to the minute which, under atropine treatment, went up to 100.

Drs. MacDonnell and Armstrong also mentioned having seen cases of abnormally slow pulse.

Stated Meeting, March 28th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Fracture of the Femur.—The following is an abstract of a paper read by Dr. Jas. Bell on "Some Cases of Fracture of the Femur, treated by plaster-of-paris splint." Three cases were reported, all occurring in children.

The first, a little boy $1\frac{1}{2}$ years of age, with simple fracture in the middle third. The second, a boy four years of age, with fracture just below the trochanter from direct violence,—being run over by a heavily-laden cart.

The third case was that of a strong, healthy boy, aged 8 years, with fracture at the junction of the upper and middle thirds. In all these cases the treatment was the same. Ether was given,

the limb extended, and the fragments brought into position, and held there until a plaster splint had been applied, extending from the toes and including the pelvis and loins. Coaptation splints of pasteboard were moulded to the leg and applied between the layers of plaster bandage.

In none of these cases has there been the slightest trouble of any kind, and in each case when the plaster was removed the union was found to be most satisfactory. In the first case there was no appreciable shortening. In the second about a quarter of an inch, and in the third a little over a quarter, but less than half, an inch. These cases were exhibited, as also an old man aged 62 years who had a bad compound fracture of both tibia and fibula just above the ankle joint. The fracture of the tibia had been oblique and about three-quarters of an inch of the protruding fragment had to be removed with the saw before it could be reduced. The limb was then permanently fixed with plaster-of-paris, leaving the wound exposed through the small opening in the bandage. The wound was dressed with Listerian precautions and the patient was discharged at the end of eight weeks with a sound leg. He is now doing his regular work (six months after recovery), and has been for some time, without any inconvenience. The writer, in summing up, thought that in a great many cases the plaster-of-paris splint was the best that could be applied to a fractured femur, notably in children, in nervous and fidgeting people and in fractures complicated with delirium tremens, also among the poorer class of patients, where a suitable bed and good nursing (which are so essential in the ordinary treatment of extension) could not be secured. He also thought that the objections urged against it for fracture of the femur were very much overrated.

Dr. Gurd said that he would not like to risk treating an adult's fractured femur in this way, as he feared that before union had occurred there would be no pressure around the limb, owing to the rapid atrophy which follows disuse and bandaging, thus allowing displacement of the fractured ends.

Dr. Blackader said he had broken the femur of an infant with the blunt hook in a difficult breech case and, assisted by

Dr. Sutherland, a gutta percha splint was applied, which answered admirably. Dr. Sutherland said he was going to use plaster-of-paris splints in these cases in the future.

Dr. Shepherd quoted Heath as saying that there was no necessity to take in the joints where plaster-of-paris was employed.

Dr. Rodger had lately used plaster-of-paris splint for fracture of the femur in a child aged 5 years with excellent results. He always uses this method of treatment for fractures of tibia and fibula.

Cases in Practice.—Dr. Bell said that this evening he had been sent for by the Coroner to make a post-mortem examination on a young man, aged 28, who had been found dead in his bed. Death was found to have been caused by the bursting of a small aneurism into the pericardium. The aneurism arose from the lower and back part of the tranverse portion of the arch. The young man had been treated as an out-door patient at the Hospital for pains in the back. Aneurism had not been detected.

Stated Meeting, April 11th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Dr. Trenholme exhibited *two pairs of Ovaries and Tubes* lately removed. One case was operated on 22nd March. Both ovaries were much diseased and enlarged to about four times their normal size. The patient was 32 years old, and had always suffered much at her monthly periods. Her sufferings have gradually increased year after year up to about November last, when she began to manifest symptoms of insanity of a melancholy religious character, with a suicidal tendency. Her monthly sufferings abated with the advent of the mental infirmity. The patient had been under the care of Dr. M. in Ontario, who suspected some disease of the internal organs of gen-

eration and sent her down to Dr. T. On examination both ovaries were found to be enlarged and tender, the uterus congested, and tender, but otherwise normal. The operation was made with the hope of benefiting her mental condition. The wound healed by first intention throughout, and the sutures were removed on the 5th day, not a drop of pus being present. The patient made a rapid recovery, and returned to her home before the end of the third week. But little could be determined as to the result of operation upon her mind, but, so far as could be judged, she seemed somewhat benefited. The future of this patient will be watched with interest and reported to this society at another time.

Case 2.—Patient, aged 22, has suffered much for several years from pelvic pains, aggravated at each menstrual period. Both ovaries tender and enlarged, uterus congested and very tender and also retroverted. Attempts at replacement and the use of a pessary had been followed by pelvic cellulitis; even with greatest care could not tolerate a pessary. Rest and local treatment relieved for a time, but when she attempted to work was again laid up. As the girl had no friends or means of support, and her health precluded service I removed the specimens now before the Society. Both ovaries (as you see) are much enlarged, undergoing cystic changes. The tubes also very much congested. This patient has so far made a most unsatisfactory progress towards recovery. There seem to be no healing powers in her, and, while no dangerous symptoms threaten life, a tedious convalescence is looked for.

Dr. Hy. Howard considered the first to be a case of acute dementia, and said that peripheral irritation, especially from the organs of generation, will some times be followed by dementia in both sexes, often taking the form of religious dementia. Dr. H. mentioned two or three cases where young men on the first night of their marriage became insane.

Purpura Hæmorrhagica.—Dr. Kennedy mentioned that lately he had had under his care four cases of this disease, all

in young children of different families. He asked if other members had seen an unusual number of those cases.

Dr. Reed said he had been treating one case at the Dispensary.

Nitroglycerine in Epilepsy.—Dr. F. W. Campbell spoke of the continual good results he is having with nitroglycerine in the treatment of epilepsy. None of the patients whom he has so treated have been entirely cured, but with all the attacks are milder and much less frequent. The usual dose which he gives is one drop of a one per cent. solution three times a day.

Dr. Trenholme asked for the modus operandi of this treatment.

Dr. Campbell said that it was not easy to say how it acted; but if it is true, as some authorities affirm, that with epileptics there is anæmia of the brain from contraction of its arteries, then we can see how the nitroglycerine is useful, knowing, as we do, its action in dilating the blood-vessels of the head, as does smelling nitrite of amyl.

Dr. Hy. Howard congratulated Dr. Campbell on his success in this treatment of epilepsy and said that the Germans classified the forms of epilepsy as follows:—1st, Those due to contraction of the cerebral vessels from irritation to the vaso-motor nerves. Here bromide of potassium is very useful. 2nd, An abnormal condition of dura mater. Bromide useless. 3rd, Due to irritation of the anterior pillars of the spinal marrow. Ether spray best for this. 4th, Lesions of different parts of the brain or cord. Of course the difficulty is to be sure of the cause.

Stated Meeting, April 25th, 1884.

DR. HENRY HOWARD IN THE CHAIR.

PATHOLOGICAL SPECIMENS.

DR. R. L. MACDONNELL exhibited a *radius* found in the McGill dissecting-room, shewing an old Colles' fracture ; also a *skull*, the parietal bones of which were very thin over the grooves for the middle meningeal artery. This was pointed out to be of medico-legal interest, inasmuch as a moderate blow on the side of the head might produce death by fracture of the bone and perforation of the vessel.

DR. HENRY HOWARD said that the late Dr. Macdonnell saved a cab-driver from the gallows by showing in court that the skull of the person whom he had struck on the head for refusing to pay him was abnormally thin in this region, death being caused as above.

Syphilitic Teeth.—Dr. MacDonnell showed a plaster cast of teeth from a boy who has been under his care for about two years suffering from well marked symptoms of congenital syphilis.

DR. SUTHERLAND exhibited the following :—

1. *Monstrosity.*—Drawing of a two-headed fœtus and skeleton of the same from Dr. Mullins of Hamilton. The child (male) had two heads, four arms, and two legs. The skeleton shewed two separate vertebral columns converging at the sacrum, and two thoracic cavities, one abdominal.

2. *Hemorrhage into the Cerebellum.*—The right lobe of the cerebellum was torn up by the force of the blood. This specimen was removed from a boy aged 13 years, who, while apparently in good health, was suddenly seized with a convulsive fit, dying almost immediately.

3. *Brain of a Monkey*—Showing the cerebellum fully covered by the cerebrum.

Dr. Sutherland also showed the *Skull and Brain of an Idiot*, the main features of which were as follows :—Of the skull : The

capacity of the cranium comes under the group of microcephalic skulls. The bones of the face are large in comparison with those of the cranium, and slant forward. The horizontal circumference taken in a plane passing anteriorly through the ophryon and posteriorly through the occipital point, $17\frac{1}{2}$ inches; arch of the vault from the ophryon to the occipital point, 10 inches; transverse circumference from one auricular point to the other, 10 inches; width between the malar bones, 3 inches. Orbits are comparatively large, $2 \times 1\frac{1}{2}$ inches. Superciliary ridges prominent. Nasal septum between them is narrow. The ophryo-alveolo-auricular angle gives a prognathic index. Temporal fossæ are deep, and ridges well marked. Basi-occipital process ascends very obliquely to articulate with the basi-sphenoid. Foramina at the base are comparatively large; the grooves for sinuses comparatively small. The brain has a low, contracted appearance, short, greatest transverse diameter being at the middle of the mass, and having a ratio to the length of 1 to $1\frac{1}{2}$. Far from being concealed, the cerebellum projects behind the cerebrum to the extent of one inch, and forms a fourth part of the whole mass. In the base view the relative preponderance of the cerebellum is again the most striking feature—

Antero-posterior diameter of the cerebrum			5 inches
Hemispheric arch			6 "
Anterior curve (fiss. of front. lobe to fiss. Rol.)			3 "
Middle "	(fiss. Rol. to par. occip. fiss.)	right side,	1 "
		left "	$1\frac{1}{4}$ "
Posterior "	(par. occip. to fiss. of occip. lobe)	right "	$1\frac{1}{4}$ "
		left "	1 "

The frontal region is short and pointed; the orbital surface but slightly marked. Temporal convolutions are large, and are continued backwards into the occipital lobes, which are exceedingly small and cannot be definitely divided into their ordinary number of convolutions. The central lobe is exceedingly small. The parts which can be detected as actual convolutions are: Frontal parietal lobules—temporal, marginal, calloso-marginal, cuneate and præcuneate lobes. Less easily the orbital, occipital and central lobes—triradiate sulcus, corpora-striata and optic thalami. On the right side the fissure of Sylvius is continuous with the post-central and interparietal sulci. On both sides the calcarine

fissure is represented by two parallel sulci separated by a ridge of convolutional substance better marked on the right side. Further development of the convolutions above and below would have concealed this ridge and left a single fissure. Cerebellum more highly developed than the cerebrum.

Dr. Henry Howard made the following remarks on the brain demonstrated by Dr. Sutherland :—With your permission, Sir, I will read a copy of a letter I wrote to Dr. Richard MacDonnell bearing date September 16, 1883 :

" I have a perfect recollection of the man that you spoke to me of. He was admitted into the asylum as a dangerous imbecile, a man with homicidal tendencies. When I first saw him I was struck with the peculiar shape of the head. It was conical. The apex of the cone appeared to be at the union of the sagittal and lambdoidal sutures. The os frontis ran back as if it formed a part of the point of the cone. The base of the cone was out of all proportion with the face, being nearly twice as large. The head and face formed two lines, and their bases united. The man's eyes were small and gray ; he was what you might call pig-eyed. His walk was that of a man with locomotor ataxia. When he came towards you, you felt as if he would run over you.

" *Physiological symptoms.*—He was generally very good-natured, but terribly impulsive ; the slightest thing would rouse him into a fury, when he would froth from the mouth and not be able to utter a word. At the best of times he spoke with hesitation, not impediment of speech.

" I know nothing of what disease he died of. It must have been a sudden death, as I never saw him in the Infirmary, and I see all the patients every week. I have no history of the man before he was admitted into the asylum. In your examination of the brain I would expect you to find the following conditions : Convolutions, particularly in the lateral and anterior portions of the hemispheres, flattened with irregular and shallow fissures ; the cells in their cortical substance (that is, of these convolutions) few and small,—in fact, teratological defect in the whole of the motor and inhibitory nerve centres. And why would I expect you to find this abnormal state ? Because the man was a very low order of imbecile, but little intelligence, and no power of controlling his impulses. I would expect to find some abnormal state of the Island of Reil, or the convolutions covering it, because of the hesitation in his speech. I would not expect to find much abnormality in the convolutions or gray substance in

the posterior lobes of the hemispheres or sensory nerve centres, because I never found any symptoms of either anæsthesia or analgesia. There was such a want of equilibrium in the man's movements, and he was such a victim of impulse, I would expect to find a very abnormal state of the mesencephalon, particularly about the basal ganglia, such as the corpus striatum and optic thalamus. I would expect the cerebellum to be large, and not covered by the posterior lobes of the hemispheres. There may be other abnormalities in the mesencephalon, but those I have mentioned I would expect to find.

"Yours always, H. Howard."

From the demonstration given you by Dr. Sutherland, you will perceive that, guided by experimental and clinical physiology, I made a good diagnosis of the teratological state of this man's brain, so far as the examination has gone, the doctor not having cut into the brain or made a histo-pathological examination of it. I admit that, in diagnosing flat convolutions and shallow sulci, I was as much guided in forming my opinion from the shape of the cranium as I was from the man's peculiar hesitation of speech and counduct. Judging by the frontal and lateral convolutions of the anterior hemisphere, we may easily conclude that there was teratological defect in the Island of Reil. Neuro-pathologists tell us that in the normal brain there are forty-four convolutions, and that sixteen of these are situated in the frontal lobes. In this brain there are only thirty convolutions, and eight of these in the frontal lobes. Mind, at least as we know it, being a phenomenon or force of matter, the psychosis must be what the physiology of the matter, of which it is the phenomena or force, makes it. This you have well exemplified in the imbecile's brain before you—the whole mass of the man's brain resembling more the brain of an ourang-outang than that of an ordinary man. It is a hard matter to give a definition of sanity, insanity, and imbecility that would be acceptable to all, particularly to judges that have to adjudicate in criminal cases. The reason in obvious. Some consider the mind to be soul or entity, causa vera; others, like myself, look upon mind, as far as we know it, as a phenomenon or force of matter. What is sanity? I answer, it is an equilibrium of mental forces or phenomena, due

to the physiology of physical organisms; and sanity or intelligence differs in degree, depending upon the physiological state of physical organisms. What is insanity? A physical disease, to be diagnosed by the person's psychosis and conduct, due to a loss of equilibrium of mental phenomena or forces, the result of pathological defect of physical organisms; and insanity differs in degree, depending upon the greater or lesser degree of the pathological defect of physical organisms. What is imbecility? It is a want or absence of equilibrium of mental phenomena or forces, due to teratological defect of physical organisms. Imbecility differs in degree, depending upon the greater or lesser degree of teratological defect in physical organisms. It is from the imbecile class that we get another class of society, viz., the criminal class, therefore the necessity of having the imbecile class cared for, but separated from society.

You perceive, gentlemen, that physical science naturally leads me to be a physiological psychologist, and I maintain that for physical effect there must be physical cause; therefore, that for all psychical phenomena or force there must be physiological cause. In the brain before you, taken from an imbecile, this truth is fully established. You may ask me, If mind is a phenomenon or force of matter, how is it that mind acts upon matter? I am sure that all nature's forces, which are phenomena of matter, whether organic or inorganic, not only act upon other forces, but react upon the cause. For example, you see it every day. Fire is a phenomenon of matter which acts on the very matter of which it is the force or motive. Atmospheric electricity or lightning is a phenomenon dependent upon the physiological state of the atmosphere. So does mind act upon the very organs of which it is the phenomenon, as well as it acts upon other organs. It is the antagonism of forces, when equal, that creates an equilibrium in nature, and not only in nature, but in our organisms. Therefore, as I have said, sanity is due to an equilibrium of mental forces, and insanity and imbecility to a loss of equilibrium of physical and mental forces. You will understand, then, that when I, or any other physiological psychologist, speak of the locality of the organ of intelligence being situated in the anterior

hemisphere of the brain, the motor organs in the lateral hemispheres, and the organ of consciousness in the posterior lobes, it is not meant by such statements to imply anything more than nerve centres with particular functions. It is not meant that such centres are independent of one another, or independent of other nerve forces. These terms are used for want of a better that would imply as much. The whole nervous system constitutes mind matter, as well as the brain and spinal cord. All centripetal nerve forces, or forces running towards the centre by means of the afferent or sensory nerves, find their centres in the posterior lobes of the cerebrum; therefore this centre is called the organ of consciousness. But should there arise any abnormal state of these afferent nerves by which the centripetal current would be cut off, there would be, so far, a loss of consciousness, although the nerve centre might remain normal. Again, if there was an abnormal state of any of the efferent or motor nerves by which the centrifugal current would be arrested, loss of motion in the peripheral nerve would take place, although the motor nerve centre was in a normal state. So is it with all other nerve centres—the eye, the ear, &c. All nerve centres are dependent upon each other for the perfect working of organic forces, and when all are normal, there is an equilibrium of organic forces, and there is an intellectual man. But when any of these forces are abnormal, then there is loss of equilibrium of forces, and a consequent loss of intellect to a greater or lesser degree, depending upon the abnormality of the affected organ. This is physiological psychology, or cause for effect, which is vastly different from the psychology of the past, which was based upon the supposition that mind was entity, or causa vera, and not what physical science or experimental philosophy has proved it to be, as far as we have any conception of it, a phenomenon or force of matter.

Our penal code is based upon the dogmatic *à priori* or speculative philosophy, which assumed that mind was entity. Hence the uselessness and absurdity of a physiological psychologist pleading before a judge of a criminal court. The ontological psychologist and the physiological, or experimental psychologist,

look upon crime from two different standpoints; therefore they never can come to the same conclusion as to cause and effect.

Since I wrote the foregoing I received the April number of the CANADA MEDICAL & SURGICAL JOURNAL, and in it perused with great pleasure, and, I hope, profit, a letter from Strasburg, over the signature "T. W. M.," in which the following occurs: "Professor Solly, before, perhaps, the most crowded house of the whole semester, detailed results of his latest experiments on the cerebrum. Solly opposes the theories of Hitzig and Ferrier with the deepest conviction that they are baseless. His results are very striking, and I doubt if it is possible for anyone to see Solly operate, remove a very considerable part of the fore-brain, and then note the results in the dogs, and still believe in the Hitzig-Ferrier localization theories."

You see in my remarks I have been anticipating "T. W. M." who, it appears to me, with Solly, misunderstands these physiological psychologists, Hitzig and Ferrier, and no matter what may be the result in dogs that have had a part of the fore-brain removed, it would be far from settling so important a question. "There may be localization, and this Solly admits, but not as we have heard of it as yet." Most undoubtedly there is localization, but not in the manner that Solly is looking for it; when he takes a wider view of the physical phenomena of force he will find it. Again, "T. W. M." says, "many suppose the localization hypothesis derives powerful support from clinics and pathology, from symptoms and morbid anatomy." Most undoubtedly they are many who believe it, and with good reason: see the brain before us this evening; morbid anatomy confirms the truth of the opinions formed from symptoms and clinical observations. No doubt but that there has been some wild writing upon the localization hypothesis, and that great misunderstanding has arisen from our terminology, nevertheless there must be physical cause for physical effect, and the effect must depend upon the physiology of matter, and our duty is, where we see effect, to search for, and, if possible, find out cause.

Stated Meeting, May 9th, 1884.

T. A. Rodger, M.D., President, in the Chair.

The following pathological specimens were exhibited :—

Aneurism of the descending Aorta—Erosion of Vertebræ—Pressure on Left Bronchus—Carnified Left Lung. Dr. Geo. Ross exhibited the specimen and narrated the case.

The specimen consisted of a large aneurismal sac occupying the descending portion of the thoracic aorta. The posterior wall of the pouch had been absorbed, and laid bare the bodies of several dorsal vertebræ, which were also considerably eroded. The left bronchus had been compressed, and the corresponding lung was airless and carnified. The aortic segments presented a sclerosed and contracted appearance, and were inefficient. The lining membrane of the aortic arch extensively atheromatous.

The history of the case began with an attack of acute left-sided pleurisy more than two years ago, for which he had been attended by Dr. Ross. Physical examination at that time showed only the usual signs of pleuritic inflammation, and of incompetency of aortic valves, with consecutive changes in the left side of the heart. Aneurism was not suspected. A year later he consulted Dr. Blackader, who referred him to Dr. Ross once more, he believing that further organic disease existed. After recovering from his pleurisy, the patient had continued to suffer from persistent pain in the left side of the chest, and shortness of breath had become aggravated. Physical signs were ; dullness over whole left lung, and respiratory sounds distant and feeble over same area. Double basic cardiac murmur. Tracheal traction evident. Aortic aneurism diagnosticated. Subsequently there were developed well-marked neuralgia of 5th, 6th and 7th intercostal nerves, which could be traced out by exquisite superficial tenderness ; also a remarkably strong, heaving pulsation at the xyphoid and neighboring parts, apparently lifting the heart

itself against the chest. The addition of these signs allowed the aneurism to be placed with certainty in the descending part of the aorta. He died with symptoms of bronchitis and increasing asphyxia.

Cast from Membranous Dysmenorrhœa.—Dr. Gurd exhibited what he thought might be a cast from a case of membranous dysmenorrhœa. The specimen was quite fresh, having been ejected from the vagina that morning. The patient, æt. 25, has been married two years; no children. For past seven years has suffered greatly during menstruation, but says what she lost has always been fluid blood with the exception of one occasion, about a year ago, when, after "missing" three months, and while at the water-closet, felt as if some small mass had come away. During the night before expelling the above cast, patient had had agonising pains for several hours. She had not seen anything for two months. The cast was the shape of the interior of the uterus, and weighed about three drachms. It was of a soft, membranous consistence and easily torn.

Dr. Trenholme thought, from the history of the case and from its appearance, it was the decidua of conception.

Dr. Gurd mentioned that the appearance exactly corresponded with what Dr. Thomas of New York describes as being a true membranous dysmenorrhœa cast, viz.: "External face soft and irregular, with perforations answering to opening of the utricular follicles. Inner face smooth, and feeling like mucous membrane."

Dr. Gardner said that it did not look like the product of conception.

The specimen was referred to Dr. Wilkins for microscopical examination.*

---

* The specimen submitted for examination was hardened in Muller's fluid. Sections were made with microtome; stained, some with picro-carmine and others with hæmatoxyline, and mounted. On examination, connective tissue, which is so sparingly present in the normal uterine mucous membrane, was found to be enormously increased in the specimen under examination; the hypertrophied condition being due to this, as well as to the unusually large number of mucous and lymph corpuscles imprisoned in its meshes. It contained also a few spindle-shaped cells. The basement membrane of the exfoliated uterine glands was considerably thickened. the glands being of normal size, and most of them containing cells undergoing degenera-

Ovariotomy—Removal of Pelvic Tumor containing Pus—Death forty-four hours after.—Dr. Gardner exhibited the tumor, and a bottle of the pus, which was odorless. Patient was unmarried, æt. 21, from the country, and with history of good health up to December last. Eight weeks ago became ill, feverish, and had repeated rigors. In the evenings would have a rigor and temperature of 103°. A tumor about size of gravid uterus, at fifth month, was noticed in the left iliac region, rounded, smooth, elastic, and not sore. She became emaciated. Her physician diagnosed a suppurated ovarian tumor. On examination, the uterus was felt anteverted and immovable. The sound entered 2½in. Roof of vagina was encroached upon by the growth. Operated last Wednesday; it was very tedious, as there were adhesions all around to the pelvis. By tapping, 32 oz. of odorless pus came away. Over the surface of the tumor was a much dilated fallopian tube. The hemorrhage was difficult to control. Patient died after 44 hours. It was either a dermoid cyst lighted up to activity or an ordinary ovarian tumor, the sac of which had suppurated.

Interrupted Menstruation.—Dr. Gardner said that lately he seen, in consultation, a lady, aged about 43, who has commenced menstruating regularly after an interval of 14 years. During her early married life she had three children, after which her husband became morally insane, was morose, and lost all affection for wife and children. She was obliged to leave him. The return of the flow excited fears of malignant disease or tumor. Examination showed nothing wrong except slight hyperplasia of the uterus.

---

tion. No increase in vascularity. No traces of villi could be found. The presence of uterine glands, and the absence of the usual changes in them associated with impregnation, also the absence of villi and of increased vascularity, prove that impregnation had not taken place and that the specimen under examination was a hypertrophied mucous membrane of menstruation, which was prevented, by the unusually large amount of connective tissue present, from undergoing the usual *molecular* disintegration associated with this function.

Stated Meeting, May 23rd, 1884.

T. A. Rodger, M.D., President, in the Chair.

Dr. R. L. MacDonnell exhibited a patient with *Keloid Tumors*, supposed to be of idiopathic origin. The patient, aged 40, had been under treatment at the Out-patient Department of the Montreal General Hospital for a tubercular syphilide upon his forehead, which is now rapidly disappearing under the iodide of potassium. It was found that he had two keloid tumors upon his body, together with the remains of a third. The first of these appeared upon the buttock, when he was 15 years of age. It was at first painful, but as it enlarged became less sensitive. After ten years it began to shrink. Nothing now remains of it but an elongated scar. Upon the breast, lying horizontally across the sternum, just below the junction of its first and second pieces, there is a tumor which is well defined, raised above the surrounding skin, firm, smooth and elastic, and of a pink and white color. It is 7 inches long, ½ to 1 inch wide, and consists of two masses, each about half the size of an egg, connected by a band of tissue which resembles greatly the cicatricial bands seen in large scars. It made its first appearance fifteen years ago, and has been steadily growing ever since. It is more itchy than painful, and is by no means tender on pressure. A third tumor exists upon the left shoulder. It is but 4 inches long, but of exactly the same shape and appearance of that over the sternum.

Dr. Hingston said he had never seen idiopathic keloid; never saw keloid disappear. In traumatic keloid the skin is never moveable, as in this case.

PATHOLOGICAL SPECIMENS.

Dr. Sutherland exhibited the following specimens:

Kidneys and Heart from a case of Chronic Bright's Disease.—Symptoms: shortness of breath for one year; frequent mic-

turition at night for several years. Before death, developed acute pericarditis and effusion into right pleura. Suppression of urine for 36 hours before death. Suffered acute dilatation of right heart. Kidneys reduced in size; weigh 100 gms., and are typical specimens of cirrhotic kidney. Heart shows slight degree of pericarditis; no effusion. Dilatation of both ventricles, especially of right, which extends $1\frac{1}{2}$ inches to right of sternum. Tricuspid orifice greatly enlarged. Muscle substance pale and fatty, but unusually tough, especially about papillary muscles.

Right Kidney, from a case of Chronic Bright's Disease, having the appendix vermiformis and cœcum attached to it.

Cirrhotic and Fatty Disease of the Liver.—Dr. Geo. Ross gave the following description of this case:—G. N., hard drinker past ten years; attack of acute nephritis three months before death; no dyspeptic symptoms till just before admission to the hospital. *On admission*—Skin moderately jaundiced (not noticed till that day); great distension of abdomen by fluid; legs œdematous; fever and delirium; severe diarrhœa, stools quite colorless; albumen and bile-stained epithelial casts in urine. Breathing very distressed; pulse weak. Aspirated abdomen, with some relief to respiration. Died comatose in five days, jaundice persisting. At autopsy, large quantity of fluid in abdomen; liver about normal size—good example of cirrhotic liver, which is somewhat fatty; obliteration of cystic duct by old inflammation; hepatic and common ducts free; intense duodenal catarrh, especially around papilla. Kidneys large, fatty and bile-stained; vermiform appendix large, and bound tightly to lower extremity of right kidney by old adhesions, which have become organized.

Myoma of Cervix Uteri, size of small orange—Removal—Recovery.—Dr. Gardner exhibited the specimen, which he had removed from a lady, aged 52. Patient had suffered from hemorrhages and pelvic distress for $6\frac{1}{2}$ years. The tumor was sessile, and dilated the cervix. The diagnosis was difficult, as there were adhesions all around between the tumor and the

cervix, with the exception of posteriorly, where was an opening through which the sound entered the womb. The uterus was retroverted. The tumor was removed without much difficulty, being shelled out with the finger. There was very little bleeding. Out of 74 cases, Dr. R. Lee had only seen four situated in the cervix. Dr. Gardner said that this was the fourth sessile tumor he had removed within a year, all the patients recovering. He made this statement as Mr. Tait, in his last edition, advocated the removal of the ovaries in these cases, as he had found that 50 per cent. of deaths followed removal of sessile myomata from the interior of the womb.

Dr. Hy. Howard exhibited, under the microscope, a slide given him by Dr. Spitzka of New York, shewing the origins of the roots of the 6th, 7th and 8th nerves from the medulla of a cat.

Varicocele of the Spermatic Veins.—Dr. Roddick read a paper on this subject. (*See Vol. XII, p.* 648.)

Dr. Hingston said the subject was interesting, as this trouble was very often seen. He prefers, when the operation is necessary, that of tying the veins and dividing between the ligatures. He had only operated three times, and now almost questioned the necessity of ever operating. The trouble comes on, as a rule, about the age of 23, and goes away after a couple of years. He was of the opinion that it was not a cause of emissions, as the testicle is often atrophied, and therefore not so active. The mind was more affected, as a rule, than the scrotum. The ring, or a truss or suspensory bandage, were often useful. He had never seen a case requiring castration.

Dr. F. W. Campbell endorsed Dr. Hingston's views regarding this very common condition.

Dr. Foley said that Mr. Jonathan Hutchinson's treatment was purgation and elevating the testicles.

Dr. George Ross thought the operation ought not to be swept away, for it has proved to be free from danger, and ought to be resorted to where the distress was very great. He has found palliative measures, such as the soft metallic ring, to be all that

is necessary in most cases. He has not found either the truss or suspensory bandage to give satisfaction.

Dr. Hy. Howard said there was no such thing as hypochondriasis. If the patient complained of pain, there must be some physical cause. He believed that at times the operation was justifiable.

Dr. Kennedy asked why so much fear about interfering with veins. He believed that where the operation is indicated it ought to be performed without hesitation.

Dr. Roddick, in reply, said that the danger of working with veins was considerable. The writer of the article on this operation in "Holmes' Surgery" says that he had a case where two joints were lost from pyæmia following the operation.

Stated Meeting, June 13th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Dr. R. L. MacDonnell exibited the following anatomical specimens made from a frozen subject:—1st, Cross section of the thorax; 2nd, cross section of the abdomen on level with first lumbar vertebræ; 3rd, vertical section of the pelvis.

Erysipelas of the Face, followed by double Cerebral Abscess.—Dr. Armstrong narrated the case. F. F., æt. 17, a student, was first seen Feb. 15, 1883. For past three weeks, from over study, has been running down in health. Has suffered from vertex headache. To-day the bridge and both sides of the nose are red, swollen, hot and painful. 18*th*—Erysipelas has extended over both cheeks and upwards over the lower half of forehead; had slight chill this morning; temperature 104°. 20*th*—Pain at top of the head still very severe, preventing rest and sleep. He answers questions correctly, but speaks in a slow, drawling manner. Says he hears nothing with right ear. Temperature 100°; pulse 56. 23*rd*—Pulse 68, and intermittent; temperature 103.5°; opened pocket of pus in forehead. 24*th*—Mild delirium present. Let out pus at root of nose. 25*th*—

Had good night; pulse 66; temperature 101.8°; answers questions rationally, but slowly. 26*th*—Gave exit to pus at inner and upper angle of right upper lid. 27*th*—Dr. Proudfoot made an incision into the orbit quite to the apex to let out pus. *March* 1*st*—Has had very restless night; much pain in the head; pulse 54; temperature 101.8°. 3*rd*—No headache; is more intelligent. 5*th*—Has had paroxysms of intense headache; Cheyne-Stokes breathing. 8*th*—Constantly moaning; no delirium; pulse 60; temperature 97.8; extremities cold. 10*th*—Troubled with vomiting; emaciation extreme. 20*th*—Growing worse. Dr. Proudfoot made three openings around the right orbit to relieve pus, which was pushing the eye forward. 30*th*—Much the same; vomiting continues. *April* 14*th*—Patient died of exhaustion after an illness of eight weeks and two days. At the *post-mortem*, the membranes of the brain were found normal, with the exception of that portion of the dura mater covering the petrous portion of the right temporal bone; here it was of a very dark color, thickened and softened. The arachnoid and pia-mater were normal. An abscess the size of a walnut was found in each hemisphere, and similarly situated on either side. They occupied the centre of the occipital and part of the parietal lobes. They were not congested. The longitudinal sinuses were healthy. Many of the symptoms usually looked for in cerebral abscess were wanting. There was an entire absence of epileptiform seizures, rigors, paralysis, or disordered sensibility; the prominent symptoms being severe headache, delirium, vomiting, a slow, defective articulation, slow pulse, and slow, intermittent respiration. The last two symptoms were evidently due to pressure.

Dr. Ross thought the abscesses were caused from the suppuration in the orbit. In the few cases of cerebral abscess which he has had, two were in the cerebellum. The absence of typical symptoms in cases of tumors and abscesses of the brain was not uncommon.

Dr. Hy. Howard mentioned a case of supposed abscess following erysipelas of the face. He thought that all organs were

liable to be affected by inflammations of the skin covering them even when bony walls intervene.

Dr. Shepherd had seen several cases of abscess of the brain, but all from ear disease. He was of the opinion that in this case it was due to pyæmia.

Dr. Proudfoot said he had often seen this patient with Dr. Armstrong, and that there had been very little ear trouble all through—nothing, in fact, to indicate disease of the ear itself. Believed the abscess was due to the erysipelas. Had examined the eye several times with negative results.

Dr. Armstrong, in reply, said why one would think the abscess due to disease of the ear was because this was so frequent a cause, and, besides, the dura mater was dark and necrosed over the petrous bone. Deafness was also present, without pressure on the auditory nerve.

High Specific Gravity of Urine.—Dr. Foley said that lately he had examined a specimen of urine of a clear amber color, containing neither sugar nor albumen, and yet having a specific gravity of 1035.

Dr. Ross said this was not very unusual. Lately he was attending a child of three years of age, who, from over-feeding, had become ill. She had an enormous appetite, but steadily emaciated. Diabetes was suspected. The specific gravity of urine was from 1037 to 1038, but contained no sugar. Examination for urea showed this present in abnormal amount. She soon recovered under appropriate treatment.

Dr. Stewart said that in all cases where there was deficient oxidation—that is, in all cases of azoturia—a high specific gravity would be seen. Correction of the diet will cure this condition.

Hysterectomy on an Insane Woman.—Dr. Trenholme read a paper on this case, of which the following is an abstract :—

Mrs. R. M. W., of London, Ont., aged 30, was married at the age of 15, previous health being good. Shortly after marriage pregnancy ensued. Excepting heartburn, nothing unusual occurred until her delivery in the spring of 1873. During labor

two severe epileptoid convulsions occurred, necessitating instrumental delivery, the child being still-born. Vomiting followed, then blindness, which latter remained for some days; she eventually recovered. Again becoming pregnant, was delivered naturally of a living child in the latter part of the same year. Epileptic fits now set in, especially at menstrual periods. On account of the rapid recurrence of these fits, a vaginal examination was made, ulceration of the os diagnosed, and treatment adopted, with improvement in local condition. No improvement in the fits. Patient took to alcohol for relief, and at last became insane. In 1882, she was sent to the asylum and entered as an incurable epileptic, with erratic symptoms. Dr. Midford of Portland, who saw the patient, recommended öophorectomy, but this Dr. Bucke did not think necessary. The patient was taken out of the asylum, womb and ovary reported contracted, and ovary attached. Vaginal öophorectomy was performed on 10th April, 1883; one ovary was found cirrhosed. Recovery took place, and patient menstruated at usual time, and has continued to do so ever since. No improvement mentally or with the fits, and patient was returned to the asylum. It being considered essential that the tubes should also be removed in these cases, and by abdominal incision, this was decided on. This was for the purpose of exploring the pelvis for any supernumerary ovary or remains of ovarian tissue, and if the uterus was diseased, to remove it also. The operation was performed April 23rd, 1884. There was no trace of an ovary or ovarian tissue. The uterus was enlarged and densely indurated, and tubes hypertrophied. The uterus and tubes were then removed. The operation lasted less than one hour, and was well borne by patient; vomiting was somewhat severe afterwards, the patient, however, apparently doing well for the first 36 hours. After this time the patient steadily continued to fail; pulse 140, and temperature 102°; death ensuing 59 hours after the operation. The report states that "ever since the operation, her fits (slight ones) have been very frequent, but at no time has there been a single unfavorable abdominal symptom, and on examination after death the wound seemed to have been almost healed by first in-

tention. Cause of death, continued and progressive shock." In speaking of this case, Dr. Bucke told me the patient had a series of epileptic fits lasting for 11 hours almost continuously, and that as she had two such attacks while in the asylum, during each of which she nearly died, he felt convinced this last attack, coming on toward the close of the second after such a severe operation, "had a great deal to do with the fatal termination." The following points connected with the operation itself are perhaps worthy of note: 1, The abdominal walls were divided in the exact median line, so that the peritoneum was reached without dividing a single muscular fibre. 2, The uterus was carried upward and retained there by means of a large rectal bougie passed up the vagina and pressed against the os uteri. 3, The uterine arteries and other vessels were secured by fine hemp ligatures, which embraced the folds of the broad ligament corresponding to each tube and ovarian ligament. 4, The uterus was divided at the inner os by a V-shaped incision, and the amputated surfaces brought together by five catgut ligatures in such a way that a simple linear incision resulted. The deeper parts of the opposed surfaces were then more closely approximated by means of quilting them with catgut, about five double or shoemaker's stitches being thus employed. 5, The deep abdominal sutures were inserted so as to carefully avoid any portion of the muscular tissue. 6, No abdominal bandage or long plaster was employed with the object of strongly encasing the abdomen, a practice fraught with no possible good, and often potent for much evil.

Upon examination of the parts removed, the Fallopian tubes were found to be occluded for about an inch from the horns of the uterus, and also very firm to the finger. The uterus was hard and about twice as large as it should have been. The cavity of the body was almost entirely obliterated, admitting the point of the probe for about a quarter of an inch only. This condition prevented any communication whatever between the tubes and uterus. Menstruation must have been from the cavity of this neck.

I much regret the issue in this case, because some two months

ago I removed the ovaries and tubes from a patient who had been suffering at her menstrual periods with increasing severity up to about six months before the operation, when suicidal mania supervened, and the monthly disappeared. I had a letter from her medical adviser a few days ago, in which he says: "Miss C. is doing well, and her mental condition much improved, though hardly up to par." It may be that there are few cases of insanity which would be cured by removal of the uterine appendages, yet, doubtless, there are some cases where the cessation of all sexual activity holds out the only hope of ameliorating their sad fate. Two classes of cases would seem to warrant the performance of the operation, viz., 1st, those cases of *imperfect sexual development* where the nervous energy is diverted and expended in fruitless attempts to perfect its growth and maturation. Here may we not hope that the removal of the uterine appendages will be found to improve the mental condition, and and, perhaps, in some cases restore to sanity. 2nd, Again, in an opposite class of cases, where the activity of the sexual organisation dominates the mental powers, may we not hope that the cessation of this controlling force will be followed by a calm and such a change in behaviour as the results of castration in the lower animals would lead us to expect. I think these points are worthy of careful study, and hope they will be tested so as to afford statistical data for future guidance.

Stated Meeting, June 27th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Crushed Hand treated by dry and infrequent dressings.—Dr. Shepherd exhibited a patient who, some two weeks before, had received a severe crushing injury of the hand. The palm of the hand was deeply incised from one side to the other, and all the short muscles of the thumb were torn out and lying exposed in the palm. The back of the skin of the hand was enormously distended with effused blood and serum. The extended

muscles were replaced, a drain inserted on the thumb side, and the wound stitched up. The back of the hand was deeply incised over each metacarpal bone to allow the effused blood to escape, and the whole dressed with iodoform and pads of naphthalized jute, covered with washed gauze, and firmly bound with an antiseptic gauze bandage. Owing to the oozing of blood the dressing had to be changed next day, at which time the drainage tube was much shortened. It was redressed as before, and as there had been no elevation of temperature, discomfort, or pain, the hand had not been disturbed since that time. Dr. Shepherd now removed the dressings before the Society, and showed that the condition of the hand was most favorable ; there was union by first intention everywhere, except where the drainage tube was, the hand had quite a normal appearance, and the dressings were only stained with a little bloody serum. Dr. Shepherd remarked that this case was an example of many he had treated in the same way, and which showed the benefit and simplicity of dry and infrequent dressings.

Dr. Rodger said that he treated compound fractures from railway accidents with dry dressings of absorbent cotton and iodoform.

Sarcoma of the Skin and Cellular Tissue about the Ankle—Amputation—Recovery.—Dr. Shepherd read a paper on this case, and exhibited both the foot and slides from the diseased structures. The following is an abstract of the paper, which was published in full in the *Medical News* of Sept. 20, 1884 :

E. M., a delicate-looking youth, aged 18, came to hospital in April last suffering from an ulcerated swelling above the left ankle. The ankle was first injured six years ago by a fall, from which he recovered so as to walk as well as ever, although a slight swelling remained. A year after, it became painful and more swollen. An unsuccessful incision was made for pus, which opening never healed. Three years ago he was kicked on this ankle by a horse, which increased the trouble. The joint itself, since the first hurt, was apparently never affected, but the swelling on the inner side slowly increased, and at different points sinuses would form. On entering hospital, the parts about the

inner side of the left ankle were of a shiny, dusky red color and considerably swollen. At the upper part were several sinuses, and near the centre a small ulcer. Pressure, which gave a semi-elastic sensation, was not painful. A free incision was made. After cutting through very thick infiltrated skin, pockets of a tissue like granulation-tissue were opened up. A neoplasm was suspected, and some of the substance from the pockets was sent to Dr. Wilkins for microscopical examination. He pronounced it a very good example of the round-cell sarcoma. Dr. Shepherd at once amputated the leg at some distance above the disease, dressing the stump with iodoform and pads of sublimated jute. Decalcified bone drains were tried, but had to be given up, as they collapsed. The case did well, the temperature after the third day never reaching 99°. The case was instructive, chiefly on account of the difficulties it presented for diagnosis and the importance of its being correct, as sarcoma, especially the round-cell variety, unless removed, is a fatal malady.

Dr. Geo. Ross asked what was Dr. Shepherd's experience with decalcified bone tubes, and why they failed in this case.

Dr. Shepherd, in reply, said that these tubes had been kept in carbolic oil, which made them too soft, spirit being the better fluid to keep them in. They use these tubes in New York, but have difficulty in getting them just right. Some become absorbed too soon ; others never absorb.

Dr. Fenwick had found the indiarubber tubes to give entire satisfaction ; in some of his cases of excision of the knee, the dressings were renewed but three times in all.

Dr. Roddick said he made some decalcified bone tubes, and used them twice, but they became clogged. He said McEwen experienced this same trouble, and now passes horse hair through the drain. This he finds prevents clotting. Another objection to them was that the bone tubes sometimes become absorbed too fast, and leave a pocket of pus undrained.

Dr. Stewart exhibited a case of *Multiple Cerebral Sclerosis, having an Apoplectiform mode of onset, and where Syncopal and Apoplectiform attacks frequently recur.* The patient, a man aged 47, hotel porter, came under observation three months

previously complaining of obstinate constipation, difficulty in speaking, and dimness of vision. He gave the following history : Three years ago, while in the enjoyment of his usual health, he was seized, while seated on the driver's seat of an hotel 'bus, with giddiness. He was at once carried home, and almost immediately afterwards passed into a state of unconsciousness, which lasted twelve hours. After the return of consciousness, he passed, in a few minutes, into a delirious state of a few hours' duration. For some three weeks afterwards, his wife says, he was " weak and useless," and " his speech was so curious that it was difficult to understand what he said." In the course of a few months he was able to speak much plainer, but not so plain as he could do previous to the attack coming on him. In the autumn of 1882, he spent some weeks in the General Hospital, and while there was under the care of Dr. Ross. Through Dr. Ross' kindness I am enabled to compare his state at that time with what it is at present. With the exception of syphilis, he never had any trouble up to the time of his present affection coming on. He formerly drank to excess, but not since the commencement of his present illness. His father died of what he calls " liver complaint." His mother and only brother are dead, but he is ignorant of the cause in either case.

Present state—Nervous system.—There is a considerable degree of mental weakness, which has only been apparent during the past year. It is progressively becoming more and more pronounced. He frequently loses his way in the streets. He is extremely emotional, laughing and crying without an apparent cause. His memory for recent occurrences is very poor, but good for trifling events of many years past. He has a very exaggerated opinion of his own cleverness. As he never received any education, he is unable to write. His speech is markedly slow, monotonous, and syllabic. The voluntary power in both upper and lower extremities is good. When he nndertakes to perform any movements, the muscles commence to tremble. This tremor, however, is not always marked ; very frequently it is absent, especially in the afternoon and evening. It is very pronounced immediately after getting out of bed in

the mornings. The nutrition of the whole voluntary muscles, except the tongue, is normal. The patellar and superficial reflexes are present. The co-ordination and muscular sense are not interfered with. There is no disorder of sensation. There is no paresis of the bladder or incontinence of urine. There is no obstinate constipation. Dr. Buller has examined his eyes. He finds simple atrophy of both discs. Vision is *nil* in the right eye, and almost so in the left. There is no paralysis of any of the ocular muscles. Hearing, taste and smell are good. There is paresis of the respiratory branches of both facial nerves, as is evidenced by the expressionless aspect of the lower half of the face, the obliteration of the naso-labial folds, the dribbling of saliva from his mouth, and by his inability to whistle and to show his upper teeth. The soft palate is very slightly paretic. When the mouth is opened, the lower jaw trembles. He has difficulty in protruding his tongue, and when he attempts to do so, it commences to tremble. There is not only difficulty in protruding the tongue, but there is difficulty in keeping it protruded. The tongue is very slightly wasted, but it is not the seat of any fibrillary twitchings. There is no impairment of either the motor or sensory divisions of the trigemminus. He has no difficulty in swallowing. He complains much of giddiness, especially when walking; objects, he says, are constantly turning around him. He is subject to both syncopal and apoplectiform attacks; both coming on suddenly, without warning,—the former lasting a few seconds, and attended with paleness of the face; the latter lasting several hours, and attended with suffusion of the face and an elevated temperature. His pulse is constantly beating between 40 and 45 times in the minute, and at times it is irregular in rhythm. His urine is free from both albumen and sugar.

The patient's present condition was then contrasted with what it was when he was in the General Hospital 18 months previously.* At that time the symptoms present were purely bulbar. Since that time the bulbar symptoms have gradually increased in severity, and, in addition, we have involvement of the optic

* A detailed report of his then state will be found in the Society's Transactions recently published. Dr. Ross gave an account of his condition at the meeting held on December 1st, 1882.

tracts, cerebrum, and in all probability the cerebellum also. Although the giddiness may be explained otherwise, it is probable that its mode of causation in this case is the formation of sclerotic nodules in the cerebellum. Whether the slow pulse is a proof of the implication of the vagus nucleus, it is impossible to say. If so, it is necessary to suppose an irritative lesion of the cardiac inhibitory nucleus. The case is undoubtedly one of multiple cerebral sclerosis, commencing in the pons and medulla and gradually extending into the cerebrum, cerebellum, and optic tracts. There is no evidence of the pyramidal columns being affected either primarily by the sclerosing of their structure or secondarily by a descending degeneration. Neither is there any proof of any other portion of the cord being involved. The case is therefore one of pure cerebral sclerosis. It is noteworthy for its peculiar mode of onset, and for the apoplectiform and syncopal attacks to which the patient is liable. Another interesting feature in this man's case is the intermittent presence of tremor. In the great majority of cases of disseminated sclerosis, tremor on voluntary movement is the most constant and most characteristic symptom present.

Dr. Geo. Ross said he had not seen the patient since he reported the case to the Society. At that time he had recently had an attack, apoplectiform in character, which he believed to have been due to a hæmorrhagic clot.

In reply to Dr. Roddick, Dr. Stewart said his patient had taken iodide of potassium.

Dr. Hy. Howard said that these cases of sclerosis vary so much that it is difficult to group the symptoms so as to tell positively whether the brain or the cord was affected primarily. Erb says that out of 200 cases, 171 were syphilitic, and the cord was first affected. Dr. Howard's own observations showed that 7 out of 10 had syphilis. A man in the asylum denied having had syphilis till the marks were found ; his first symptom was impotency. He (Dr. H.) had never seen a case cured. Insanity in those cases of progressive paresis was caused by reflex action from the cord where it is diseased to the higher nervous centres, which are the lowest organized.

Cancer of the Stomach; rapid growth of the tumor.—Dr. Campbell related the following particulars of this case:—Had been sent for early in May to see Mrs. L., aged 41, who was complaining of pain over the stomach, but not very severe. As her mother had died of cancer, he was pretty sure this would prove to be the same trouble, although no tumor could, as yet, be made out. Within a week vomiting set in. *June 1st*—Rather worse. *5th*—Could keep nothing on her stomach. On the 7th, could feel a nodule, which, in 48 hours, increased wonderfully from being the size of the top of the thumb to that of an egg. The vomited matters were the color of bile—never bloody. The patient died a week later. The pylorus and lesser curvature were implicated. There was stenosis, but not much dilatation of the stomach. Pain, which was never very severe, was less toward the end. There was no cachexia present.

Dr. Trenholme said he had had two similar cases. In one, there were no symptoms till within three or four days before death, although a cancerous mass the size of a turnip existed, which involved the stomach; the other was that of an old gentleman, who ate well up to the last, and had very little pain.

Stated Meeting, Sept. 26th, 1884.

T. A. Rodger, M.D., President, in the Chair.

Enlargement of the Spleen.—Dr. Armstrong exhibited a boy 11 pears of age, whose spleen extended a couple of inches below the umbilicus. Enlargement dated from an attack of typhoid fever three years ago. The lad's mother says that on three occasions he has had attacks of unconsciousness, followed by paralysis of one side, and lasting a few days. There is a diminution of red-blood corpuscles and an increase of white. Improvement in general health had followed the use of Liq. Arsenicalis, and for a time the spleen became smaller.

Dr. Wilkins said he had attended the boy off and on for years. He was not sure if what he took to be attack of typhoid

were that, as six or seven months after the boy had a feverish illness, when he became semi-comatose for several days. The spleen at times reached below the crista ilii. Had repeatedly examined the blood; usually there were but one quarter the normal number of red-blood corpuscles. Found no absolute increase of white-blood corpuscles. For a time quinine caused the spleen to get smaller.

Traumatic Tetanus in a woman aged 40.—Dr. Wilkins exhibited part of a foot, also a piece of sole leather, the size of half a pea, which had been driven up into the foot by standing on a nail. This occurred on Saturday. The following Wednesday she was seized with spasms, and removed to hospital on Thursday. It was thought that a piece of the nail might be in the soft tissues of the foot, but after careful examination by Dr. Roddick, nothing was found; but it was deemed wise to remove two toes and the parts for one inch back. On dissecting the piece removed, Dr Wilkins found the bit of hard leather resting on a nerve filament. The symptoms were not much lessened by the operation, the patient dying thirty hours later, probably from asphyxia. Dr. Wilkins said if he had another similar case he would try excising the nerve higher up, say in the leg.

Dr. Trenholme said he had had a case very like this one, where a boy got a splinter of wood into his foot. The splinter was pulled out and the parts healed nicely, but in ten days tetanic spasms followed, ending fatally. Dr Trenholme found a very small bit of wood, surrounded by a drop of pus, in the foot. Dr. Fuller, who performed the *post-mortem*, traced the nerve from the wound to the base of the brain, and found it all inflamed. In the spine, the membranes, as well as the cord, were congested. Some of the fluid from the spinal canal was injected into a dog; paralysis followed, which lasted several days.

Dr. Bell said that he had seen several cases of traumatic tetanus in the hospital. A man was stabbed in the instep with a pitchfork; a bit of stocking was found at the end of the wound. Another case was that of a girl, who had a nail run into her heel. After death he dissected the parts, and found a sliver of iron resting against a nerve filament, which was swollen and œdema-

tous. A third case was where a man was hurt from a fall on the buttocks; symptoms of deep-seated suppuration ensued. The man died seven days after the injury. No *post-mortem* was allowed in this case. On theoretical grounds, Dr. Bell believed success might follow amputation and keeping the patient well under the influence of opium—in fact, pushing the opium as far as possible.

Dr. Henry Howard hoped surgery would prove an aid in these cases, yet he doubted if it were possible. He related several cases which had been under his care—one being that of a son of the late Dr. Mount's, where tetanus followed a scratch on the buttock.

Uterine Myoma; Removal; Death from Exhaustion.—Dr. Wm. Gardner exhibited the specimen, which was about the size of an orange. Patient, aged 52, had had severe hæmorrhages for four or five years. On examination, the above tumor was found, and although very weak, it was deemed wise to remove it, which was done piecemeal. Patient did well for 36 hours, dying from exhaustion 56 hours after the operation. The discharges were never at any time fœtid. The womb was irrigated repeatedly, and at times continuously, by means of the double irrigation tubes. Dr. Browne assisted at the operation. Dr. Gardner said it was well known that uterine fibroids frequently kept up menstruation for long after the usual time, and were often the cause of the menorrhagias seen at the menopause. Profuse menstruation at the climacteric is not normal, and should be followed by a uterine examination in order to prevent operations being performed upon women already much weakened.

Dr. Trenholme thinks one is not warranted to explore the uterus by the occurrence at this period of menorrhagia alone. The question of operating for fibroids depends upon whether we can control the hemorrhages till after the menopause or not.

Infant Feeding.—Dr. Blackader read a paper on this subject. (*See* Can. Med. & Surg. Jour. *for November, page* 203.)

Dr. Alloway said that infants objected to milk digested with Pancreatic Extract on account of its bitterness. He also spoke of the benefits of using very fresh milk, and the means used to

obtain a regular supply, as seen in some cities in the old country, where she asses and goats are brought from door to door and the quantity required there and then milked.

Dr. Gurd asked if the observations made by other members agreed with his, viz., that artificially fed infants were, as a rule, larger than others.

Dr. Campbell agreed with Dr. Blackader that only the minimum of food found necessary should be given. He condemned the more convenient long-tubed bottles as being not only injurious in themselves for many reasons, but also as tending to make the mothers less careful altogether of their infants. It was so easy to put the baby down, with the bottle beside it, and "let it go as you please." His experience coincided with Dr. Gurd's, that artificially fed infants were larger and heavier than others. He (Dr. Campbell) found that stall-fed cows gave a more acid milk, and as many of our city cows were stall-fed, this would account for the reason why milk foods so often disagree.

Dr. Henry Howard said he had noticed that sometimes a mother's milk, whilst agreeing well with her own thriving child, when given another to nurse, the foster child would fail and pine away. When a student in Dublin, had often seen cows led from door to door to be milked for the customers.

Dr. Cameron said if the milk were only partially digested, the bitter taste would not be present. He uses gum water as a diluent for milk in preference to any starchy preparation, believing it less apt to sour. He spoke strongly against the milk supplied to the city, which sometimes for hours was churned in the waggons on their way from the country. Some cows were kept in the city, but these were mostly badly housed and fed. A patient of his, an infant on milk diet, three months old, was suddenly taken with choleraic symptoms. The milk was stopped and it got well; again it was put on the cow's milk, and the diarrhœa, etc., returned. Dr. Cameron went to the milkman's to seek for the cause of this, and found that the day the baby was first taken ill the cows had been fed with old cabbage leaves and turnip tops. He thought the Health Officer ought to look after dairy inspection.

Dr. Wilkins said he had had very satisfactory results with the use of pancreatised milk; has always used Benger's preparation of Pancreatine. At times he has found it necessary to rest the stomach, and so has used it per rectum. Anæmic mothers don't give the quality of milk required, though the quantity may be plentiful. Here he orders barley water, and the child to be nursed less frequently. He said that a drop or two of sour milk left in the tubes of a bottle was enough to set up lactic acid fermentation in a whole bottleful of milk.

Dr. Armstrong had found milk digested with Benger's preparation very useful. On one occasion he fed a three months old infant for seven days entirely by the rectum, the child recovering from its illness.

Dr. Blackader said that the fresher the milk the better for infants. Boiled milk was much more difficult to digest than unboiled. He has noticed that bottle-fed infants were either very large and fat, or just the opposite.

Annual Meeting, Oct. 10th, 1884.

T. A. Rodger, M.D., President, in the Chair.

The following officers were elected for the ensuing year:—

President—Dr. Roddick.
1*st Vice-President*—Dr. Alloway.
2*nd do.* —Dr. Trenholme.
Treasurer—Dr. Molson.
Secretary—Dr. Gurd.
Librarian—Dr. Reed.
Council—Drs. Geo. Ross, Kennedy and Rodger.
Publication Committee—Drs. Cameron, George Ross, Kennedy, and Bell.

The retiring President, Dr. Rodger, in his address, spoke of the great loss which the Society had sustained in parting with so active a worker as Dr. Osler.

Dr. Osler was unanimously elected an honorary life member.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, October 24th, 1884.

T. G. Roddick, M.D., President, in the Chair.

Missed Abortion.—Dr. Alloway read a paper on this subject. (*See Can. Med. & Surg. Journal for Dec., page* 257.)

Dr. Kennedy said he did not like this new name, "Missed Abortion," especially if applied to the retention of a dead fœtus over five months old. He said it was well recognized that the fœtus might die, become mummified, and be retained, or, after its death, it might be expelled and the membranes alone be retained.

Dr. Cameron also took exception to the term "missed abortion," as not being precise. He mentioned that McClintock made fun of the term by saying that when a woman went to full time it was a case of missed abortion. He prefers calling a blighted ovum a *mole.*

Dr. Trenholme said there was no question as to a dead fœtus being retained in some cases for several weeks or months. The only point was as to whether the specimen exhibited was so retained or not. The indications led him to question its long retention, and to regard it as one of a series of early abortions. In those cases of retained fœtuses which had come under his observation, he had found an abnormal condition of the decidua —the reflex decidua being distinct and separate from the uterine decidua, which is strongly adherent throughout. In this way the enveloped fœtus became a sort of tumor, frequently causing hæmorrhage, and its growth being interfered with, the subse-

quent death of the fœtus is due to the compressing force of the reflex decidua. In his cases he found the decidua very strong indeed, a good deal of force being required to rupture it and allow of the removal of the fœtus. Dr. T.'s theory is that there is sufficient vital union existing to prolong the retention, while the pressure is such as destroys life. It is only when the contents of the uterine cavity become separated to such an extent that the contained mass acts as a foreign body that uterine contractions ensue. This is true whether the contents to be expelled is an early or late product of conception. The fact of the non-union of the reflex and true deciduæ accounts for menstruation during pregnancy ; also for the well known fact that frequently no harm follows the use of the sound, nor even the application of remedial agents to the cavity. Of course the separation of any part of the placenta would be apt to be followed by uterine contractions.

Dr. Campbell said he had a patient with symptoms indicating treatment by means of applications to the interior of the uterus. He first passed a probe and afterwards painted with a solution of iodine and also acid. nitrate of mercury. This was done four or five times before the real cause of her trouble was found out by her aborting.

Dr. Alloway said, in reply to those gentlemen who took exception to the term "missed abortion," that if a better one could be suggested he would gladly accept it. Dr. McClintock's little joke was simply an *Irishism*, and was not intended to convey any literal meaning. Dr. A., however, drew attention to the error of confusing the terms Missed Abortion and Fleshmole. He referred to his definition of the terms relatively, as given in the body of the paper, which distinctly shewed that the term missed abortion alluded to "*a condition*," and that a mole was "*the product*" of this condition—in fact, a pathological specimen ; and that the terms could not be used with any other meaning or relationship. In conclusion, Dr. Alloway said he felt much gratified with the kindness shown by the members who had discussed his paper, more especially for their complete recognition of the correctness of his views relating to this interesting subject.

PATHOLOGICAL SPECIMENS.

Dr. Sutherland exhibited the following specimens :—

1. *An Appendix Vermiformis, containing* 14 *snipe shot.*—This was removed from a patient who died of chronic Bright's disease, and who had been a lover of game.

2. *Intestines from a case of typhoid fever*, where the patient died on the ninth day of illness, and before ulceration had taken place. The Peyers' patches were swollen and raised about a quarter of an inch. This patient was admitted into the hospital on the sixth day in an unconscious condition, and remained so until death, three days later.

3. *A Heart, showing calcification of the valves of a congenitally narrowed aortic orifice.*—Dr. Ross said this had been removed from a gentleman, a traveller, stopping at one of the hotels. He had suddenly taken ill with alarming symptoms, and was sent to the hospital. When admitted he was suffering from dyspnœa, and died shortly afterwards.

4. *Abscess of the Liver.*—Patient, a woman, was admitted into the hospital under the care of Dr. Molson, with the following symptoms : Pain and tenderness in both iliac fossæ ; worse in the right. Had a quick pulse, and was suffering from dysentery. She died in 48 hours. There was a history of having had an attack of illness, with similar symptoms, about a year ago, and lasting five weeks. The *post-mortem* showed signs of an old peritonitis in the region of the right iliac fossa ; also signs of recent peritonitis in right hypochondriac region. Flakes of lymph were adherent to the under surface of the liver. On removing this organ pus was seen oozing from a small opening on its under surface, where rupture had taken place. Fifty or sixty ounces of pus were removed from the cavity in the liver.

5. *Horse-shoe Kidney*, also from a hospital patient aged 32 years. The right half was healthy ; left half was filled with pus. A large calculus in the pelvis blocked the exit of urine ; several smaller calculi were seen in the calyces. The microscopic appearance of the right kidney was normal. Both lungs were riddled with cavities. This patient had been admitted with

phthisis. On admission, the urine contained 50 per cent. of albumen. There was excessive pain in the left lumbar region, with frequent micturition. At first he passed large quantities of water, it became less, and, during the last 36 hours, scarcely any came away.

6. *Pyo-pneumo-Thorax, showing ulceration from a large lung cavity into the pleura.*—This specimen was removed from a man aged 27, admitted into hospital August 1st, 1884. He was a stonecutter, of steady habits, a moderate drinker, and belonged to a phthisical family. He had typhoid fever eight years ago; had coughed and expectorated ever since. He had failed rapidly during the last seven months, and had suffered with severe cough, fever, and sweating. Four days before admission he took a sudden sharp pain at the left apex, and, shooting downwards, was accompanied with great dyspnœa. There were now present signs of softening tubercular deposit in the right lung; the left was loudly tympanitic, with feeble amphoric respiration. The heart was pushed to the right. Whilst in hospital there was extreme dyspnœa (orthopnœa), with irregular hectic fever and profuse sweating. On Aug. 5th, distinct succussion sounds were heard; breathing amphoric, loud and distinct to the base. Dulness up to the tenth rib on leaning back; loud, clear resonance down to twelfth rib leaning forwards. This condition persisted till death took place from exhaustion on the 17th September.

Special General Meeting, Oct. 31, 1884.

T. G. Roddick, M.D., President, in the Chair.

This meeting was called to consider Dr. Tuke's report on the Insane Asylums of the Province of Quebec, and generally to discuss the treatment of the insane in this province.

Dr. Campbell, who opened the discussion, strongly denounced the present farming or contract system, and deplored the lack of skilled medical treatment in our asylums.

Several resolutions were read and spoken to, Drs. Trenholme, Shepherd, Kennedy, Geo. Ross, Reed, G. T. Ross, Cameron, McConnell, Mills and the President taking part.

The following are some of the chief objections mentioned by the speakers to the present system of managing the insane poor of this province: That it led to cheap everything—attendants, care, fare, etc.—and to an entire absence of skilled medical treatment, which latter want resulted in a minimum of cures and the excessive use of mechanical restraint.

Dr. Cameron read portions from the Lunacy Act for the Prov. of Quebec, passed last June, and which he characterized as being very loose, incomplete, and apparently drawn by an amateur. No blame was attached to the ladies of the Longue Pointe Asylum or to Dr. Henry Howard, the onus being placed on the Government.

Dr. Henry Howard, who was not present, sent a written communication criticising Dr. Tuke's report and expressing his disapproval of the contract system.

A committee was formed to draw up resolutions embodying the sentiments expressed at this meeting, which resolutions were to be forwarded to the Government.

Stated Meeting, Nov. 7th, 1884.

T. G. Roddick, M.D., President, in the Chair.

At a largely-attended meeting of the Society, the following resolutions were unanimously passed:—

Resolved,—That this Society has every reason to believe that the statements contained in the Report of Dr. Tuke of London, Eng., upon our Provincial Lunatic Asylums are in every material respect true and well-founded;

That these statements show a most lamentable state of things as regards the general, and especially the medical, management of these Institutions;

That it appears to this Society to be the imperative duty of the Provincial Government to institute a thorough investigation by competent persons into the entire system of management of the insane poor in this Province;

That the "farming" or "contract" system, either by private individuals or by private corporations, has been everywhere practically abandoned, as being prejudicial to the best interests of the insane and producing the minimum of cures;

That, in the opinion of this Society, all establishments for the treatment of the insane poor should be owned, directed, controlled, and supervised by the Government itself, without the intervention of any intermediate party;

That the degree of restraint known to be employed in our Provincial Asylums is, according to the views of the best modern authorities, excessive. That the ablest European, American and also Canadian alienists have almost entirely given up any method of mechanical restraint. That these facts call urgently, in the name of humanity, for reform in this direction in our Provincial Asylum.

Resolved,—That this Society concurs fully in the opinion already expressed by Dr. Tuke in his report, to the effect that "the authority of the visiting physician (Dr. Henry Howard), appointed and paid by the Government, has been hitherto almost, if not entirely, *nil*." His hands have been so tied that he could not be held responsible for the way in which the Asylum has been managed.

Dr. Alloway exhibited the following Pathological specimens:

1. *A Fœtus of two months*, complete in its sac.

2. *A Fœtus three months old*, shewing arrest of development of the abdominal walls, and through which opening the bowels protruded.

3. *A Fibroid growth the size of an almond*, removed by him from the anterior wall of the vagina, just inside the introitus. The woman had suffered from hæmorrhages, and her health was broken down, largely, no doubt, from septic poisoning, as the little growth was sloughing. Since its removal the hæmorrhages have ceased, and the patient's health has very much improved.

Dr. Trenholme exhibited a *pair of Ovaries* removed by him the day before from a woman aged 28 years, who has suffered from pelvic distress since she was 14 years old. Six years ago she had a child, after a difficult labor, from which time her sufferings have been worse, quite incapacitating her from her duties. On examining her he found in Douglass' fossa a tumor which he took to be a diseased and enlarged right ovary, and decided to operate. On opening the abdomen, the left ovary was also found to be enlarged to about the size of an egg and

filled with fluid. It was first removed, along with its tube. Much greater difficulty was experienced in removing the right, as it was firmly fastened down in Douglass' pouch. It was about the size of a large walnut, and filled with pus. Dr. Trenholme said the patient was doing well; pulse 82, temperature normal.

Perforation of a Typhoid Ulcer in the Colon; Peritonitis.—Dr. Ross exhibited the specimen and related the case. The ulcer was situated about a foot from the ilio-cœcal valve. The patient was sent to hospital on the 21st day, with a good pulse, temperature 99° to 100°, the only bad symptom being tympanites. Dr. R. remarked that it was very unusual to find a perforating ulcer in the situation of this one. They are found much more commonly in the ileum. Tympanites had been a prominent symptom, and resisted all treatment. It did not arise from constipation and retained decomposing fæces, as is sometimes the case, as care had been taken to prevent this, and the autopsy showed the bowels to be nearly empty. It made the prognosis bad. The onset of perforation and subsequent peritonitis were well marked.

Dr. Trenholme asked why not perforate through the abdominal walls to let out gas.

Dr. Ross said there were no distressing symptoms present, and it was not clear that this was always a safe proceeding.

Dr. Hingston remarked that it was a common thing for a farmer to open the distended abdomen in cattle.

Sycosis.—Dr. Wood read a paper on this subject, of which the following is a brief resumé:—Much confusion has resulted from a want of agreement among authorities as to a definition of sycosis. It has been defined so as to include pustular eczema, tricophytosis barbæ, and acne indurata, and it is yet a question whether there is a disease which is distinct from these—a true sycosis. Liveing says this is a non-contagious disease of the hairy face, which is neither eczema, nor acne, nor a syphilide. The diagnosis is often difficult, but the microscope ought to discover the mycelium and spores of the *tricophyton tonsurans*, while the moist patches of eczema and the distinctive characters of acne should prevent mistakes. The affection is not common,

is usually obstinate, and only yields to long-continued and persistent treatment. Epilation and the inunction of some simple ointment are all that are commonly required. The hairs should be extracted two or three times a week, and where the pustules and tubercles are the result of the inflammatory changes incident to acne, to eczema, or to ringworm, additional appropriate treatment should in each case be resorted to.

Dr. Wood showed a patient of his recovering from a lengthened attack of sycosis.

Dr. Shepherd said it was easy to diagnose sycosis from acne and eczema, and spoke highly of Shoemaker's treatment of parasitic skin diseases with the oleates.

Dr. Blackader gave his experience in treating *tinea tonsurans* by means of oleate of copper ointment. Thirty cases occurred among the children of the Hervey Institute during the past spring and summer. Marked improvement and cure followed the use of an ointment of the strength of from 1 to 8 to 1 to 12, very little irritation being produced.

Dr. Cameron said dermatologists were finding out that vaseline, though very elegant, was not so useful a vehicle as lard for making ointments intended to cure the parasitic skin diseases. Lard, having more affinity for animal tissues, penetrates deeper. The best vehicle for oleate of copper is oleic acid. The oleic acid, of English manufacture, should first be heated, after which the oleate of copper is to be stirred in.

Dr. Hingston said it was necessary to make first a correct diagnosis between eczema and tinea sycosis. Tinea sycosis is a simple inflammatory disease, so that parasiticides were not necessary. He uses epilation of the diseased hairs only, a bread and milk poultice, and attendance to the digestion. He always cures this way, and in a few days.

Dr. Campbell had seen six cases of the parasitic form of sycosis, and only one of the non-parasitic. He had been successful in curing six or eight cases of tinea tonsurans lately with the oleate of copper ointment.

The President made a few remarks, in which he said that he had seen but very few cases of this parasitic form of sycosis.

Stated Meeting, Nov. 21st, 1884.

T. J. Alloway, M.D., 1st Vice-President, in the Chair.

Dr. Sutherland exhibited two pathological specimens.

1. *Myeloid Disease*, involving all the tissues of one thigh, in a girl aged 18. When first seen, the symptoms were those of sciatica; a fortnight later a small lump was felt, which, in another two weeks, had enlarged to double its size. A lance was plunged into it, as it felt like an abscess; only blood came away. About a month after, she was admitted into the hospital; but too late for surgical interference, there being no healthy skin left in the neighborhood.

2. *Heart having warty Aortic valves.*—This was removed from a man aged 30, a hospital patient, in whose brain was also found softening of the parts supplied by the right middle cerebral artery. About ten months previous to entering hospital he had recovered from an attack of hemiplegia. In this case there was a history of repeated attacks of acute rheumatism.

Abnormalities.—Dr. Wm. Gardner described two abnormalities which he had lately come across in his practice. The first was a case of double uterus, os and vagina, the latter being divided equally by a septum. Patient was a young married woman, not pregnant. The second case was one of absence of the urethra in a sterile married woman. Where the urethra should be is a pit about one inch deep, at the end of which is an opening with a fringe-like border leading into the bladder. The opening was large enough to easily admit the finger into the bladder. She has never suffered from incontinence, except during the past few months, and then only when in the upright position.

Dr. Trenholme had lately seen a woman with a double vagina, os and bicornuated uterus.

Idiopathic Neuritis of the Brachial plexus.—Dr. Stewart showed a well-marked case of this disease. The patient is a

man aged 35, and, until seven months ago, when his neuritis suddenly set in, enjoyed perfect health. There is complete paralysis of all the extensors of the fingers and hand, also of all the flexors except the ulnar, which is only in a paretic state. There is complete loss of the thumb movements. He cannot flex his forearm, neither can he pronate or supinate it. Shoulder movements normal. There is marked atrophy of the paralyzed muscles. The deltoid and the spinati are also in a state of atrophy, but it is slight compared with the wasting of the paralyzed muscles. The paralyzed muscles do not respond to the faradic current. There is both quantitative and qualitative change to galvanism. The A O Z < K S Z, while the A S Z=K S Z. The skin of the paralyzed hand is glossy, and at times presents bluish spots. There is marked anæsthesia in the ulnar region of the fingers and hand. All other parts are perfectly normal in their sensation. Very slow improvement is taking place from galvanism.

Tait's Operation.—Dr. Trenholme reported six cases of removal of the uterine appendages, with their results. The operations were made during the year ending April 1st, 1884. The similarity of these cases renders it unnecessary to give details of each, the symptoms being intense pelvic suffering directly connected with the continuance of the menstrual function. In all the cases the ovaries were enlarged and diseased; in some the tubes were also affected. The operations were made without the use of the spray, but the hands, instruments and sponges were cleansed in a weak solution of carbolic acid and water. The ligatures used were of shoemaker's white thread, No. 20, carbolized over night. This ligature has always been the doctor's favorite in abdominal surgery, and although he has tried silk, he would not do so again. The plan followed was to use single ply of the thread, and where the tissues to be embraced were more than could be safely included in a single ligature, he resorted to the application of several ligatures, rather than use double or multiple thread. This thread, untwisted, is a safe ligature, never has failed in his hands, and has never given rise to any perceptible irritation, even when as many as forty or more

have been left in the abdominal cavity. Dr. Trenholme also discards abdominal bandages, trusting to the deep silver sutures to secure coaptation. Horse-hair is used for the superficial sutures, the wound is dressed with carbolized gauze, and over all two or three strips of strong adhesive plaster are placed to lessen the tension on the sutures. By carefully dividing the sheath of the rectus muscle (on either side), and not wounding the muscle itself, and also by carefully excluding the muscular tissue from the deep sutures (*a la* Goodell), we secure, as well, perfect union by first intention. This was the case with all the reported cases where this plan was carefully followed. In all these cases a slight metrorrhagia occurred on the second or third day, lasting several days; also, all the patients suffered for several months afterward from flushes of heat and hot perspiration. In one case the patient had a slight bloody discharge on two separate occasions, of about ʒi each time. As to the results, cases 1 to 3 have been followed by satisfactory results, the patients being now capable of performing the household duties appertaining to their respective stations in life. In all but one of these cases the cure has been complete, and even in the exceptional one, the return to health continues to advance with progress of time, the chief impediment being due to hernia of the bowel. Cases 4 and 5 were complicated with mental disturbances. No. 4 has not been appreciably benefited by the operation. Time is still needed to determine what improvement may yet take place. Case 6 is of special interest. Here suicidal mania followed long-continued disease of the uterine appendages. With the supervention of the mania, the pelvic suffering ceased. Both ovaries were diseased, and their removal has been followed by most gratifying results to patient in every way. Her mind has been greatly improved—no more mania—and her physical condition so improved that she is able to take an active part in the duties of a farm life.

In the discussion which followed, Dr. Trenholme advocated the study of mental diseases in connection with disorders of the generative organs, both male and female, and said he believed a great field was opened up worthy of further exploration. He

also spoke of the great benefits to society that would result from the castration of tramps and confirmed criminals.

Dr. Hy. Howard said he believed in a physical cause for mania. In case No. 6, operated on by Dr. Trenholme, anæmia of the brain may have been caused by menorrhagia. He said men have become maniacal the first night of their marriage from anæmia of the brain, being produced by peripheral irritation. Good food, air and exercise will cure such cases. Cases of mania produced by anæmia of the brain are more curable than if caused by hyperæmia.

Dr. Gardner congratulated Dr. Trenholme on the result of his cases, and on being one of the pioneers of an operation which has attained such a good position in surgery. He had operated in four cases. One, a very difficult case, with numerous adhesions and troublesome bleeding, proved fatal from peritonitis. In two of the remaining three the result was satisfactory, but the recovery slow. The third still suffers very much, probably from pelvic inflammation, set up by a long cold drive on her way home after the operation. There could be no doubt of the propriety of the operation in cases of palpable disease of the appendages, with local symptoms, with or without neurotic symptoms sufficiently severe, and in which other treatment failed to relieve. As to cases with purely neurotic symptoms, aggravated at the menstrual periods, there is room for doubt as to the propriety of the operation. Hegar and other eminent German authorities, at the last International Congress, had declared in favor of it, while Spencer Wells and others were opposed to it. The neurotic element, in many of the cases, must be recognized and treated. The successful gynæcologist must also be in some measure a neuropathist. It is probable that certain cases reported cured by this operation might have been spared the mutilation, and cured by a treatment mainly tonic and neuropathic. Every gynæcologist must admit that there are cases of enlarged diseased ovaries in women capable of a good deal of activity—mental and bodily. All his patients had suffered more or less from the disturbances, vascular and other, which attend on natural menopause. In none of them had ventral hernia occurred, but he

had taken care that each patient was fitted with an efficient abdominal supporter before being allowed to leave her bed.

Dr. Armstrong said he had operated twice for the removal of the tubes and ovaries. His first case was a success every way, though recovery at first was very slow. His second case has fully recovered from the operation, but sufficient time has not elapsed to say what will be the permanent effect.

Stated Meeting, Dec. 5th, 1884.

T. G. Roddick, M.D., President, in the Chair.

Dr. Shepherd exhibited a large tumor which he had lately removed from the left parotic region. The patient was a woman aged 47. Tumor appeared as a small lump below the ear four years ago; it increased slowly, but was not painful until lately. The tumor, during the last six months, had grown more rapidly and had produced some facial paralysis. There was no interference with the circulation. The tumor was partly beneath the sterno-mastoid, and firmly fixed by the parotid fascia. The removal was tedious and difficult, owing to tumor not being very well defined. The external carotid artery was tied, and the fascial nerve had to be sacrificed. The patient recovered rapidly, and had no elevation of temperature. On examination, the tumor was found to be a fibro-adenoma. The second day after the operation an ulcer developed in the cornea, which took some time to heal. This was probably caused by an edge of the bandage coming in contact with the open eye.

Tumor of Bladder.—The President exhibited a cystic papillomatous tumor which he had some weeks previous successfully removed from the bladder. A microscopic section of the tumor was shown. The history of the case is as follows:—Geo. T., aged 53, was admitted into the Montreal General Hospital, Oct. 27th, complaining of much pain and difficulty of micturition, and pain over the region of the bladder, with frequent over-distension.

Symptoms began ten years ago with occasional difficulty in micturition. Three years ago, noticed blood in the urine for the first and only time. At this time he made water every hour, with pain before the act; pain chiefly referred to the end of the penis and neck of the bladder. Catheterization now became frequently necessary. When admitted into hospital, made water every hour, but from a bladder distended to the extent of a couple of pints would evacuate three or four ounces. There was constant hyper-distension of the bladder, forming a distinct tumor, extending sometimes to near the umbilicus. There was great pain in the left iliac region, especially during the act of micturition. Prostate very slightly enlarged. The bladder was sounded carefully, but nothing definite could be made out. Dr. Roddick thought the case was either one of encysted stone or tumor of the bladder, so decided to explore the bladder carefully after the manner of Sir Henry Thompson. This he did on Nov. 12th. A staff was introduced, and the membranous portion of the urethra cut down upon. The finger was then introduced through the prostatic portion, and almost immediately something was felt. On examining more carefully, Dr. Roddick discovered a pediculated tumor attached to one side of the neck of the bladder. This he freed with his finger-nail and extracted. The tumor was almost as large as a hen's egg. For a few days the man had some elevation of temperature, but now he was convalescent, and was passing his water by the urethra. Dr. Roddick remarked that he had several times explored the bladder as in this case, but that this was the first time he had ever discovered a tumor.

Dr. Molson presented to the Society two large calculi which had been lately passed by one of his patients, who had had frequent attacks of renal colic and bloody urine.

Lead Poisoning.—Dr. Mignault then read a paper on two cases. The first case was well marked. Patient, a young woman, came under his care at the Hotel Dieu Hospital, suffering from wrist drop, constipation, colic, and distinct blue line of gums. There was also extreme wasting of the extensor muscles, and also of the muscles of the ball of the thumb; this wasting had

been rapid. The source of the lead poisoning had been traced to some pickles which the patient had eaten in large quantities three or four times a day, having been advised to do so for loss of appetite. Lead was found in large quantities in the vinegar used to preserve the pickles. There had been several similar cases in the neighborhood where the woman lived which had all been traced to the eating of pickles. In the second case, the poisoning was also due to the eating of pickles. In this case, besides the wrist-drop, blue line, colic, &c., there was marked melancholia and mental depression.

Dr. F. W. Campbell looked upon mental depression as frequently present in lead poisoning. He advised large doses of iodide of potassium to be given—half to one drachm doses.

Dr. Gurd explained that the common kinds of pickles were kept in glazed earthen jars before being bottled, and that oxide of lead was used for glazing the cheaper earthenware; this, when brought in contact with vinegar, was dissolved out in the form of the soluble acetate of lead, and so poisoned the pickles.

Drs. Gardner, L. Smith and Molson, each reported a case of lead poisoning. Dr. Molson's case ended fatally, and delirium was a marked symptom from the beginning. The man had been employed mixing paints for some two months, and the attack commenced with colic, later there was constipation and mental depression, then delirium. The wrist-drop only came on during the last three weeks. Patient died of exhaustion.

Dr. Jas. Bell said that there were two kinds of lead poisoning—acute and chronic—and he had, whilst medical superintendent of the Montreal General Hospital, seen many cases of both kinds. He believed, in the chronic form wrist-drop was a remote symptom, and not accompanied by colic, as in Dr. Mignault's cases. The blue line could be caused by other sulphides than lead. He thought the rapid wasting of the muscles not a common symptom in lead poisoning, and suggested that Dr. Mignault's first case was not one of lead poisoning at all, but due to some trophic changes. It looked very much like a case of polio-myelitis of spinal cord.

Dr. Jas. Stewart asked if the deltoid muscle was affected. He said in any case of paralysis the extensors were the first to suffer, and, last of all, the intrinsic muscles of the hands. If these were affected early, he thought Dr. Mignault's first case might not be entirely due to lead poisoning.

Dr. Hy. Howard wanted to know how the iodide of potassium acted, and the effect of the lead on the nervous system. He said: It is a remarkable fact that in all cases of muscular atrophy and paralyses of parts from poisons, so much depends upon the poison as to how the nerve centres are attacked. For example, in the case under consideration, lead poison, the highest centres —that is, intelligence—although the lowest organized, is the last attacked; the first being the afferent or peripheral sensory nerves, rendering the parts anæsthetic. Now, because the trophic nerves are paralyzed, they can no longer perform their function; and, in accordance with the natural law of waste and supply, or of evolution and dissolution, it is all waste and no supply, consequently atrophy of the part that has been deprived of its supply. The next stage is the natural consequence of the first, the peripheral nerve lesion—that is, motor paralysis—and why? Because the roots of the motor nerves leaving the spinal cord, as well as the cord itself, are supplied by these trophic nerves, consequently these parts lose their supply, and the waste causes paralysis of the motor nerves. Thus do we account for the atrophy and paralysis of a certain group of muscles from the toxia of lead poisons, and, I have no doubt, for other functional symptoms that we find in cases of lead poisoning, remembering that all functional symptoms are due to structural cause. With regard to toxia from alcohol, it is a fact that the first organs affected are the highest nerve centres—viz., intelligence. A man first becomes a fool from the poison, then the sensory nerves becomes paralyzed, and he is anæsthetic—that is, general anæsthesia; and the last stage of the poisoning in both is hemiplegia.

Dr. Mignault, in replying, said that the symptoms of the acute and chronic forms might exist together, the one passing insensibly into the other. In the first case the deltoid muscle

was apparently normal. He was certain that the muscles of the thumb atrophied early and rapidly.

Hydrochlorate of Cocaine.—Dr. Buller, on being asked to give his experience with this new local anæsthetic, said :—On the 7th of November I commenced using the new local anæsthetic (cocaine) in operations upon the eye, and have had an opportunity of testing its merits in quite a variety of cases. Under its influence I have performed iridectomy five times, extracted two senile cataracts, removed four tarsal cysts, discision of capsular cataract twice, opening of the canaliculi twice, and operation for obstruction of the lachrymal duct once. I have always used a four per cent. solution. The results have been gratifying, but not entirely satisfactory. The first iridectomy was for artificial pupil on account of a central leucoma of long standing. Two instillations at an interval of five minutes. Ten minutes after the first instillation, grasping the conjunctiva with fixing forceps caused no discomfort. The operation was performed in the usual way. In reply to my question, "Did you feel any pain?" the patient, an intelligent man, said "No, I cannot say that I did." In iridectomy for lamellar cataract, preliminary iridectomy for senile cataract, and for acute glaucoma, I was equally fortunate. In one case of iridectomy for commencing staphyloma following ulceration of the cornea from purulent ophthalmia, the patient complained considerably of pain during the operation, notwithstanding four applications of the drug at intervals of five minutes. There was in this case an incomplete anæsthesia, ascertained by testing the relative sensibility of the conjunctiva of the other normal eye. Perhaps the still somewhat infiltrated and swollen conjunctiva had been rendered less susceptible to the action of the drug by the recent inflammatory process. In one case of senile cataract, the anæsthesia was all that could be desired ; in the other, the patient became restive before completion of the incision, and give me a good deal of trouble before the operation was satisfactorily completed. In both, the result of the operation was perfectly satisfactory ; and I may say that I have not observed the slightest ill-effect from the use of cocaine up to the present time. In one

case of discision of a partially absorbed traumatic cataract, repeated instillations failed to produce any anæsthetic effect, and the patient complained of pain quite as much as if no anæsthetic had been used. The same solution had proved perfectly efficacious upon another patient a few minutes previously. It would therefore seem that some eyes cannot be rendered anæsthetic by the use of a 4 per cent. solution of cocaine. For the removal of tarsal cysts, the pain was only trifling after three or four instillations of the solution; so also in slitting the canaliculi, and was certainly diminished even in the operation of opening the nasal duct.

Dr. Gardner had removed a urethral carbuncle without producing pain by means of cocaine.

Dr. Alloway had opened a large retro-vaginal abscess painlessly with a 4 per cent. solution of cocaine.

The President reported a painless operation upon himself by means of cocaine. He had, in fact, pulled out one of his own double teeth. He applied a 4 per cent. solution by means of two bits of lint for some 15 minutes before "putting on" the forceps. The tooth was firmly fixed, and he only felt a slight pain towards the end of the operation.

Neuritis of the Brachial Plexus.—The discussion on this case (exhibited at last meeting by Dr. Stewart) now took place.

Dr. Hy. Howard said: Whether the etiology of this case be idiopathic or traumatic, or, more properly speaking, whether it be due to chemical or mechanical lesion, it is a case in proof of my theory that peripheral, or trophic, or sensory paralysis is followed by muscular atrophy and motor paralysis. This case went to prove the now established physical fact that alterations or change of animal organisms—that is, of structure—creates change of function, and that change of function is necessarily followed by change of conduct. These truisms explain how the sane man of yesterday is the insane man of to-day; how the rascal of yesterday is the saint of to-day; the immoral of yesterday the moral of to-day; the irreligious of yesterday the sancti-

fied of to-day; and how so many people deceive themselves, mistaking structural and functional changes for supernatural cause of effect.

Stated Meeting, Dec. 19th, 1884.

T. G. Roddick, M.D., President, in the Chair.

PATHOLOGICAL SPECIMENS.

Dr. Kennedy exhibited some inky-black sputum expectorated by a middle-aged man, a painter, who enjoys good health. He has been expectorating this black sputum for about seven years; never much at a time, but lately is rather worse. It comes just after a slight cough, and is at first viscid. He has never inhaled carbon. There are over his body several melanotic spots. Dr. Kennedy suggested that he may be eliminating pigmentary matter from the lungs. It was not chemically examined. Dr. Kennedy promised to further investigate this case, and bring it again before the Society in the form of a paper.

Malignant Disease of the Œsophagus, causing stricture.—Dr. Ross exhibited the specimen and related the case:

J. W., aged 54, was admitted to Hospital Dec. 10th, 1884, suffering from a severe attack of acute pleurisy, with effusion, commencing twelve days before. *Previous history*—Difficulty in swallowing for six months previously, beginning with sudden obstruction in swallowing glass of hot spirits; since then was unable to swallow solids, but could readily take liquids; was a hard drinker, and a subject of constitutional syphilis; no family history of cancer. Owing to patient's serious condition, no examination by bougies was made, but he stated that three months before admission Dr. Perrigo had treated him for stricture of gullet, with some benefit; he stated also that he had lost weight rapidly since beginning of illness. Patient, from the first, was very weak, gradually sank, and died on Dec. 17th. *Autopsy*—Right pleura contained 40 ozs. thick, yellow, very turbid serum. Right lung collapsed; surface covered with a thick sheeting of

lymph; no pneumonia. Left lung normal. Heart normal. Œsophagus, at level of bifurcation of trachea, presented a large, deep ulcer, with shreddy base measuring three-quarters of an inch by one-and-a-half inches; edges not indurated, but rather excavated, although base is thickened and a small lump of glands beneath base were enlarged and firm, and projected into left bronchus, shewing beneath the mucosa (which is intact) as a firm mass the size of a large bean. No secondary nodules elsewhere. No signs of syphilis. On microscopical examination, base of ulcer showed an epitheliomatous growth, the cells being arranged in columns and nests.

Dr. Perrigo said he had passed a bougie down this man's œsophagus on two or three occasions, with relief to the dysphagia for a time.

Dr. Mills said that German investigators had proved by experiments that a band of muscles of the œsophagus or intestines may be excited into contraction and remain so for a long time, like a tetanic spasm of a voluntary muscle.

Dr. Smith said this patient came to see him about three or four months ago, complaining of difficulty in swallowing and cough. He diagnosed malignant disease, and sent him to Dr. Perrigo.

Dr. Mignault said he had a patient, a nun, who has periodic attacks of dysphagia, which he was always able to relieve by a hypodermic of morphia. His patient, ten years ago, drank by mistake a strong solution of potash. He believes there is an old cicatrix in her œsophagus, which becomes irritated and sets up spasm.

Dr. Campbell said that a duodenal ulcer will at times allow food to pass over it and at other times will not. He related briefly the history of a patient of his who died from hæmorrhage of an ulcer in the duodenum, in whose case these symptoms existed.

Dr. R. L. MacDonnell read a paper entitled "*A Year's Medical Work in the Out-patient Room of the Montreal General Hospital*," in the course of which he read very many reports in brief of some of the more instructive cases he had met with

during the year ending May 31st, 1884, together with remarks upon the clinical features peculiar to the cases noted, as well as to those met with in out-patient practice generally. The paper included more particularly remarks upon three cases of lead palsy, in two of which no distinct history of metallic poisoning could be traced, while in the third, colic and wrist-drop had followed the prolonged use of tinned vegetables. Two patients with locomotor ataxia had presented themselves, and one of tabes in its pre-ataxic stage, the symptoms present being recurring gastric attacks, one with hæmatemesis, at first supposed to be caused by alcoholism, followed by temporary derangement of vision (Argyll-Robertson pupil), slight numbness of the feet, and loss of knee-jerk. There was a history of syphilis in all. A case of primary lateral sclerosis of the cord, in a boy aged 12, was also described.

Fissure of the Anus.—Dr. Kennedy related a case which he was treating by passing a rectal bougie. The use of hydrochlorate of cocaine renders the operation painless.

Stated Meeting, January 9th, 1885.

T. J. Alloway, M.D., First Vice-President, in the Chair.

Case of Hernia, with great hypertrophy (elephantiasis) of scrotum.—Dr. T. D. Reed showed photographs and gave the following account:—The patient, a French-Canadian, aged 60, applied at the Montreal Dispensary recently for treatment of œdema of left leg. On examination, he was found to have a very large pyriform tumor projecting from the pubis, reaching to within one inch of the patellæ, measuring $14\frac{1}{2}$ inches in length and 30 inches in great circumference. The man had had an irreducible hernia of the right side of several years' standing, and thought the scrotum had been increasing in size for about fourteen years. The dragging of the mass, the estimated weight of which was 14 lbs., on the pubic tissues had resulted in burying the penis completely, which could be traced from a groove

on the side of the tumor. Dr. Reed considered the mass to be in the upper third, hernia; in the middle, hydrocele; and the lower, hypertrophied scrotal tissue. There was a sinus in the solid portion, from which exuded a watery fluid. The surface of this part was uneven, and the skin adherent. The patient had no difficulty with the bowels, and the belly was rotund. To urinate, the patient would elevate the mass with the hands, and pushing himself against some object, as a chair-back, bring out the glans. The urine was examined for albumen, with negative result. Under treatment, the œdema of the leg diminished. Surgical interference with the tumor was refused. The patient could walk long distances at a moderate pace.

Removal of an enormous stone from the bladder.—Dr. Hingston exhibited to the Society an enormous calculus removed by him from the bladder by the lateral method. He said his object in doing so at so late a period was in consequence of the advocacy on this and the other side of the Atlantic of the supra-pubic method for stones of large size, an operation which, even with Petersen's modification, he considered a serious one. He said the *Medical News* of Philadelphia had mentioned the removal of a stone weighing three ounces by the supra-pubic as worthy of record; and Sir Henry Thompson, in the *British Medical Journal* for July, had stated: "no incisions can be made in the region which belongs to that operation" (the lateral) "through which a calculus of three ounces or more can be extracted." The calculus Dr. Hingston exhibited weighed five ounces and five drachms when removed in July 1873, by the lateral method. It was a somewhat flattened ellipse, and measured in breadth, $2\frac{1}{4}$ inches; length, $3\frac{1}{8}$ inches; thickness, $1\frac{1}{4}$ inches; greatest circumference, 9 inches. It was composed of uric acid, with one end covered with a half-inch coating of phosphates. The patient, a young man, 21 years of age, made an excellent recovery, and returned to his home in Syracuse, in the State of New York.

Dr. Wood exhibited a man with only one leg, the tibia of which, he thought, had had a piece knocked off by the man's having fallen on a shovel.

Dr. Hy. Howard said it was difficult to be sure, as everything was healed up, and there was no other leg to compare it with.

Dr. Alloway related the history of a case which he stated was of more interest from its extreme rarity than of serious importance to the patient. The patient, a young married lady, mother of two children, youngest about four years of age, consulted him about one year ago concerning a pain in her right side, backache, and general decline in health. On making a vaginal examination in Sims' position, a large cyst-like, blueish body occupied the whole of the posterior fornix space, and so overlapped the vaginal portion of the cervix and os uteri that it was with difficulty the cervix and os could be at first discovered. The cyst proved to be purely submucous, and its fluid contents separated the mucous membranes from the submucous tissues from a point extending from the os up the posterior surface of the vaginal cervix, and down a short distance on the posterior vaginal wall. At this time there was a slight catarrhal condition of the cervix, but no evidence of there having been ulceration or previous attack of pelvic inflammation. He kept the patient under observation for nine or ten months, and observing no change having taken place in the cyst during that time, concluded that it probably resulted from injury incurred during the last confinement, and had existed ever since. From its size and position, it was quite possible for it to have acted as a bar to conception during all this time. A piece of the wall of the cyst on the cervix was removed with the scissors, and about an ounce of greenish, limpid serum escaped. The fornix and vagina were packed with cotton, and the patient kept in bed for a week. There is a slight discharge of serum yet, and it may require, at some future time, brushing over internally with iodine or other irritant to complete the obliteration. The abnormal symptoms complained of at the time by the patient have disappeared. Dr. Alloway exhibited a diagram showing the position of the growth, and said he had never met with a like condition, nor had he been able to find such an one recorded.

Stated Meeting, January 23rd, 1885.

T. J. Alloway, M.D., First Vice-President, in the Chair.

PATHOLOGICAL SPECIMENS.

Broncholiths.—Dr. Smith showed two small calcareous masses about the size of half peas which had been expectorated by an old man having senile catarrh. He has been expectorating four or five of these daily for the past eight or ten years.

Dr. Bell said he thought these little masses may have come from calcareous bronchial glands similar to some he has met with in the post-mortem room of the General Hospital.

Large Tonsillary Calculus.—Dr. Smith removed this from a boy aged 10 years. It weighed forty grains and measured 2 by $1\frac{3}{4}$ inches.

Dr. Bell said he had removed a calculus from Wharton's duct which had caused so much inflammation as to mislead some other doctors into believing the patient had malignant disease.

Uterus with Fibroid Tumor; Tait's Operation.—Dr. Trenholme exhibited the specimen and related the case. The uterus was removed post-mortem from a woman aged 30, upon whom he had performed Tait's operation on the 7th of this month. She had suffered for years with pain on the left side and dysmenorrhœa in spite of all treatment. An examination revealed a uterine fibroid of the left side, with an enlarged ovary, and the parts about were thickened. Before the anæsthetic was administered, a hypodermic injection of $\frac{1}{6}$ grain of morphia and 1–1000 of atropine was given. The operation was a difficult one. There was an inch and a quarter of adipose tissue before the sheath of the rectus was reached. When the hand was got in, a membrane was felt, which was perforated by the fingers. The right ovary, twice its natural size, was first removed along with the tube. It was much more difficult to get the left into view. It was removed (not enlarged), with but the fimbriated end of the tube. There was smart hæmorrhage, which was, after a time, controlled, and the wound brought together. Peri-

tonitis set in twelve hours after. In forty hours it was thought there might be fluid, so the wound, which had healed completely, was opened, when five or six drachms of pus escaped. The wound was left open and the pulse improved for a time, but she died 76 hours after the operation. She had urinated naturally, but there had been no escape of flatus. She died from peritonitis and septicæmia. Drs. Armstrong, Wood and J. J. Gardner were present at the post-mortem. The uterus was found anteflected, and on its left cornu was a small fibroid tumor.

Dr. J. J. Gardner, who performed the post-mortem, said there were the signs of a general peritonitis ; pus was all over the intestines. Both sides of the omentum were adherent to Poupart's ligament. The perforation made by Dr. Trenholme was seen.

Dr. Cameron, who assisted Dr. Trenholme, said there were present evidences of previous inflammation, and that a great deal of handling and forcing were needed. The situation of the tumor and the adhesions made it difficult to sponge all the blood out. The fibroid tumor, from its situation, made it at first appear as if they had a double uterus to deal with.

Dr. Stewart asked why a drainage tube was not used.

Dr. Trenholme said he had never yet used one. He would have used it in this case, but thought it was not needed.

Dr. Stewart said it was the practice for surgeons who do not use full antiseptic precautions to use a drainage tube. This patient died from suppurative peritonitis.

Dr. Hy. Howard asked if a surgeon would not be justified in staying his hand from proceeding further when so much difficulty and danger presented themselves.

Dr. Wm. Gardner said that if adhesions contraindicated operation, only about half the cases operated on would be attempted.

Dr. Alloway remarked that this case showed how difficult it was to prevent sepsis in cases where old inflammations existed. The symptoms here tally with Emmet's views, viz., that the dysmenorrhœa is due to a parametritis.

Ovarian Cysts from a case of Double Ovariotomy.—Dr. Gardner exhibited the sacs of the two cysts removed by him from a woman aged 31, unmarried. They were of slow growth and began on the right side. The only distress had been pelvic pain. The right side of the abdomen was distended to about the size of an adult's head. The left tumor was the size of an orange, and the uterus lay between them. The first cyst was easily managed. It was much more difficult to get at the second, as it lay below and behind the uterus in Douglas' fossa, and was adherent to the uterus. It burst, and the contents being a tar-like fluid, it was not easy to remove it all. Warm carbolic acid solution was used, but did not dissolve it. The fluid in both cysts was of a dark-brown color, from old hæmorrhages into them. A glass drainage-tube was used. Patient died the third day of peritonitis. No pus escaped till the very last. About two ounces of bloody serum came away each day. The operation was performed under strict antiseptic precautions. It is the experience of all that long operations are very fatal. Sir Spencer Wells' percentage of deaths in double ovariotomies is 34.15. Mr. Lawson Tait's figures give a better shewing.

Dr. Alloway exhibited a *decidual cast of the uterus about twenty days old.* The points of interest were the distinctness with which the embryo-formation could be seen through the membranes, and the formation of the decidua reflexa as it arched over the ovum-sac, but which had not been quite completed, leaving a transparent facet looking towards the interior of the uterus, and through the membranous walls of which the embryonic cell-formation could be distinctly seen. Dr. Alloway drew attention to the evidence this specimen bore towards the correctness of Cost's views in regard to the formation of the decidua reflexa.

A LOCAL ANÆSTHETIC.

Dr. Lapthorn Smith read a paper on the use of a mixture of about equal parts of chloral hydrate and camphor as a local anæsthetic. He stated that when placed in the solid form together in a bottle they soon produced a clear, thick liquid,

which, when applied on a piece of lint, covered with oil silk, to a painful surface, complete analgesia resulted. He reported three cases in which he tried it with good success. The first was a whitlow of the finger, which the patient refused to have opened. Shortly after applying it the pain disappeared, and three days later it was lanced and the pus let out without the patient, a young lady, experiencing any pain whatever. The second case was a very painful bubo, which completely disabled the patient, a gentleman, from doing his work. The mixture of chloral hydrate and camphor was applied frequently on a piece of lint, with the result that a few hours after the first application he was so much relieved that he returned to his duties next day, and fluctuation becoming evident a few days later, it was opened, the operation causing only about a quarter of the usual amount of pain. The third case was an operation for the removal of a large sebaceous cyst of the face, which was removed after the frequent application of the local anæsthetic for several hours previously by means of a brush. The incision in the skin was almost painless, but it produced no effect upon the deeper structures to which the cyst was firmly adherent. The action of the anæsthetic is much less marked on healthy than on inflamed and painful skin.

Dr. Reed was familiar with the compound. G. E. Saunders of Montreal had shown that this is a simple mixture of the ingredients, and not a true chemical compound. Dr Reed would suggest the solution in chloroform as a topical application.

Dr. Stewart had used a mixture of chloral and camphor for neuralgia, but now uses menthol.

Dr. Gurd has found an ointment made by mixing half a drachm each of camphor and chloral hydrate to one ounce of lard of great benefit in pruritus.

Stated Meeting, Feb. 6th, 1885.

T. G. Roddick, M.D., President, in the Chair.

Sarcomatous Disease of the Femur and Acetabulum.—Dr. Roddick exhibited the specimen and related the case. The patient, a young man, sprained his hip five years ago by falling through a trap in a hayloft. He appeared to recover completely, but in a few months became lame, and had pain, at times getting better. A year ago he had to take to crutches. Last June Dr. R. found roughness of the bones of the joint, and indistinct fluctuation in Scarpa's space. Nothing was done at that time. He was sent to the country, where he remained for two months, returning to hospital last October. The abscess was now opened. He had hectic fever and lost flesh. He went away, but returned again in January, with suppuration about the joint. Becoming worse, it was decided to amputate at the hip-joint, which was done. There was no hemorrhage of any consequence, but the patient never rallied, and died twelve hours later.

Dr. Sutherland exhibited the following specimens:—

1. *A Gall-bladder containing thirty-two stones.* This was removed from a subject (female) in the dissecting-room of McGill College. Three or four of the stones were very large, measuring an inch square.

2. *Bladder and Kidneys of a man*, from whom two months previous to death Dr. Roddick had removed a vesical polypus by median cystotomy. The bladder was much dilated and extensively hypertrophied. The ureters also were seen to be dilated. The kidneys were in a state of suppurative interstitial nephritis, or typical surgical kidneys.

3. *Malignant Disease of the Stomach, showing obstruction at the pyloric orifice.* A portion of the liver, the gall-bladder, ducts, duodenum and pancreas were also shown. Secondary deposits were seen in the latter and in the glands. The bile ducts were pervious. At the autopsy the following was noted:

Emaciation and jaundice ; 160 ounces of bile-stained fluid was removed. The liver appeared small and the stomach very large, extending seven inches below the ensiform cartilage. On raising the left lobe of the liver, a large hard mass was felt, which involved the pylorus and apparently part of the duodenum. On slitting up the stomach after its removal, the mucous membrane was seen to be pale and anæmic. At the pylorus was a thick ulcerated ring, studded with little red granular ulcerations, and occluding the entrance into the duodenum, preventing the passage of the little finger. A mass about the size of an egg was situated in the pancreas, near its head—probably a secondary deposit, as it was not actually ulcerating. Jaundice was produced by small masses in the gastro-hepatic omentum pressing on the hepatic duct.

Dr. Geo. Ross said there were several points of interest in the clinical history of this case. The gentleman came to him a year ago complaining of dyspepsia ; his general health was not good ; he said he had been failing. Improvement followed upon treatment. He saw him again in the spring, when he complained of vomiting at intervals of some length. There was no pain after meals, or ever. At intervals of one, two or three days he would have heartburn and an uneasy feeling ; he then would get over a basin and empty his stomach. He would have no nausea, or pain, or retching. On examination, the stomach was found dilated, extending below the umbilicus. Its movements were plainly visible, and splashings could be heard. The patient was anæmic, and becoming thinner. Malignant disease of the pylorus, with dilated stomach, was diagnosed. No tumor could be felt. He was advised to enter hospital in order to have the stomach regularly washed out. Coming to hospital some weeks later, no dilatation of the stomach could be made out ; it was not subsequently present. He had occasional vomiting of frothy material containing *sarcinæ ventriculi*. He became more comfortable under treatment, though he lost flesh. There was never any pain. He remained in hospital about a month. After this he gradually became jaundiced, and continued to lose weight. At no time were there symptoms of gastric trouble, except the

occasional vomiting. There never had been any hæmorrhage. A short time before death, an indistinct fulness could be made out at the pyloric end of the stomach. It proved to be scirrhus, as was shown by slides exhibited under the microscope by Dr. Johnston. Dr. Ross said the pylorus would not admit the little finger, and why there was a dilated stomach at first, and not later, was not easy to explain.

Dr. Kennedy said that perhaps the circular muscles at the pylorus, from irritation, were spasmodically contracted, but when the disease advanced they might have been destroyed, and so relieved the spasmodic closure of the orifice.

Dr. Robt. Bell (Ottawa) then read a paper by Dr. Percy W. Mathews, on "*Notes on the Diseases among the Indians of York Factory, Hudson's Bay.*" (*See* Canada Med. & Surg. Journal, *March*, 1885.)

Dr. O. C. Edwards, late secretary of this Society, and now in medical charge of Treaty No. 4 Indians, Indian Head, North-West Territory, being present, made a few remarks on some of the diseases among the five thousand Indians on his reserve. Syphilis was very prevalent, and one of the most powerful agents in weakening the Indians. Years ago they led a wandering life, had plenty of food, and were well housed in huts made of buffalo hide. Now, having entered into treaty, they are placed on reserves, making themselves practically prisoners of war. Coming in contact with the whites, they have become infected with syphilis, and as they very seldom apply for treatment, it has spread. The Indians attribute their present condition to the extermination of the buffalo. The Government has tried to make them agriculturists, with but very little success. Phthisis is a most fatal disease, and is usually accompanied with hemorrhages. They apply for assistance, but it is almost impossible to help them, owing to their being badly housed, and they will mix what one gives with their own medicines. Along with this is the noisy "tom-tom" constantly going on outside of any sick man's house or tent. Prolonged lactation is common. A squaw often nurses her child till it is three or four years old. An Indian has as many wives as he can keep,

often five or six. They appear to be exempt from toothache. They are great tea drinkers, and often mix tobacco with the tea. They smoke a great part of their time, swallowing the smoke, which they let out again by the nostrils. They never have inflammatory rheumatism. He has only seen one case of epilepsy, and that was in a half-breed. Measles comes as an epidemic, and is almost as bad as smallpox. For snow-blindness, they apply tea leaves. In the month of March, one must protect their eyes against this. Dr. Edwards said that prior to meeting with the whites, they were very moral and honest; now they don't know what these virtues are. He has visited Indians who still live by hunting, and far away, whom he found honest and moral.

Dr. Hy. Howard remarked that Butler, in his "Great Lone Land," said there was no such thing as impurity or dishonesty when he travelled among them.

Dr. Robt. Bell's experience was that the civilized are immoral. Squaws think they are benefiting their race by having a child to a white man. Labor is effected while on the knees, and is of short duration. He knew of one squaw who was drawing a load of wood, and who, after a halt of half-an-hour to have her baby, proceeded on with her load. Menstruation comes on when about 12 or 13 years old. They are not very regular, often skipping three or four months, caused by hardships and bad food. As a rule, they lose very little.

Dr. Proudfoot said he had been a good deal among the Indians up by Lake Huron, and found phthisis to be very fatal with them.

Dr. F. W. Campbell had noticed that phthisis had killed a good many of the Micmac Indians of the Bay of Chaleurs.

Dr. Trenholme said he knew of a French-Canadian woman in Montreal who was a grandmother at 25 years of age.

Stated Meeting, Feb. 20th, 1885.

T. G. Roddick, M.D., President, in the Chair.

Abnormal Muscular Slip.—Dr. Trenholme exhibited a man, aged 45, having an elevated congested-looking mark about 15 inches long, running obliquely from under the clavicle to the ensiform cartilage.

Dr. Shepherd believed it to be an abnormal muscular slip from the external oblique muscle to the pectoral.

Ulcer of the Stomach; adhesion to the liver; abscess between.—Dr. Bell exhibited the specimen and Dr. Roddick related the following history of the case: Mrs. J. sent for him three years ago for a profuse hemorrhage from the stomach. Ulcer was then diagnosed. One year later she had a second bad hemorrhage. A few months after recovery from this last attack she broke her radius, which united well. After a time she failed in health, became blanched, and felt as if she lost blood, though no more ever came by the mouth. On being sent for again, Dr. R. P. Howard was asked to see her in consultation. At this examination, they found the stomach dilated. Dr. Howard concurred in the diagnosis of ulcer of the stomach. The patient would eat, and, after a day or two, would vomit apparently all the food taken the couple of days previous. Washing out the stomach was suggested, and the case was handed over to Dr. Bell to carry this treatment out. Dr. Bell said that for a time his patient stood the treatment, but afterward she declined to have anything further done. She only lived six weeks longer. He got permission from her friends to allow him him to go to the vault and open her to examine the stomach. On the posterior wall of the stomach, midway between the œsophageal and pyloric openings, is an old ulcer; at this point the stomach is also adherent to the liver, and between the two is a sac containing pus, with an opening into the stomach.

In answer to questions, Dr. Roddick said the stools never showed signs of blood. He fed her at one time for a month per rectum on peptonized foods.

The Single Suture.—Dr. Alloway gave the following particulars;—Of the last thirty cases of parturition I have attended in primiparæ, eight have suffered from laceration of the perineal body sufficiently extensive to warrant the application of the *single suture.* In one of these cases, the suture was not applied until six hours had elapsed since the delivery. Union in all of these cases has been complete and permanent. In all of them I have employed the most perfect antiseptic course of post-partum treatment, to which I attribnte a large share of the success in obtaining primary union. The application of the single suture was suggested and practised by me two years ago for the first time. In the *American Obstetrical Journal* of February, 1884, I have given a detailed description of the operation, a short epitomé of which is all that is necessary here. A straight perineal needle three inches long should be used. I have had these needles for this operation made by Messrs. Codman & Shurtliff of Boston, and they can be obtained at Messrs. Lyman & Sons, Montreal. No other needle can be used with the same satisfaction. I use, absolutely, Snowdon's iron-dyed silk, No. 13. A strong needle holder completes the outfit necessary. During the examination of the wound, sponge it well of all blood-clots with a solution of bichloride. Then pass the needle through the skin about half an inch from the edge, and at a level with the very beginning of the tear. With two fingers of left hand in the rectum, force up the recto-vaginal cellular tissue and make the needle glide rapidly, though steadily, beneath this cellular tissue, as close to the wall of the rectum as possible to make its exit at a corresponding point on the opposite side of the tear. Now sponge the wound carefully again, and bring the edges of the wound together by tying the suture fairly tight. It will be noticed now that there will be some bulging or gaping of the part of the wound between the suture and sphincter ani, and will be very tempting to apply another superficial suture; but my advice is—*don't*, it will be frustrating the very object of the operation,—avoid all *unnecessary* sutures as you would other foreign bodies between the edges of the affixed surfaces. This gaping fissure will shrink away by the third day, and the two

edges will come together in close union. I will now speak of one or two cardinal points which are *absolutely* necessary in doing this operation. First, Be sure that the needle, in no part of its course, appears in the vaginal wound. The corners of the laceration at the entrance and exit of the needle, where the wound is sometimes deeply fissured and jagged, require especial care on this point. To guard against this, the thumb of the left hand should be kept always in the wound over the course of the needle, constantly feeling for it; and should you detect the needle in the surface of the wound in ever so small a part of its course, it should be withdrawn and deeper tissue taken up. After the needle has made its exit on the right side, it should not be completely drawn through until the operator has again examined its track and become satisfied that the suture will be completely buried in all its course. If this care is not specially taken, and a part of the suture should gain entrance to the wound, a pus pocket will be very likely to form, and the operation will fail. A suture passing through the cavity of a wound is a foreign body, but passing around outside of the wound, it cannot interfere with union. The certainty of success of this operation hinges largely on this simple fact, and it should be well borne in mind. The suture is removed on the eighth day by dividing it with a scissors, and it will be found to give a loop of about three-quarters to one inch in length if the divided ends are reunited. The second point of importance lies in the after antiseptic treatment; and I will certainly not hold the principle of the operation responsible for failure unless this point is carried out as advised. I hold this position on the same grounds as a surgeon of the present day who would not feel inclined to hold himself responsible for the successful issue of an amputation or severe lacerated wound, the after-treatment of which had been taken out of his hands and handed over to the tender mercies of an ignorant nurse and a few well economized soiled rags. I cannot conceive why there is so much opposition to the dressing of puerperal wounds.

The main part of the post-partum antiseptic treatment consists in irrigating the wounded passage with a $\frac{1}{2000}$ mercuric solution

once daily. The first irrigation is performed the day following the delivery, and again at each morning visit until the eighth day, when the suture is removed and union found complete. In carrying out this procedure, the patient is gently lifted, while lying on her left side, to the edge of the bed, the nates hanging just over the bedboard. A small rubber apron (a quarter of a yard square) is slipped under the hips and tied over the crest of the ilium. In this way a gutter is formed which carries the fluid as it runs from the vaginal passage into a receiving basin on the floor. The reservoir of the irrigator is then filled with the mercuric solution previously prepared. The nurse holds the reservoir in her hand at the proper level, and the physician introduces the glass tube into the vagina after he has first allowed some fluid to run into the basin to drive out the air. As soon as the nurse notices that the fluid has become exhausted to about an inch from the bottom of the reservoir, she informs the physician, and he withdraws the glass tube from the vagina and allows the remaining fluid to run on and cleanse the external parts. A napkin is then applied, and the patient gently lifted back in the bed and allowed to remain on her back for a short time. I never allow the nurse to touch the parts under any pretence whatever. Her duty consists in giving the patient her prescribed diet and attending to the infant. A saline is administered every morning, and the bowels gently moved over a bedpan adjusted by the patient herself.

I will now illustrate by these diagrams on the board that directly after a bad laceration takes place, and before the suture is passed, the vaginal passage is much elongated and the uterus slightly anteflexed. The uterus can now hardly be reached by the fingers without introducing the whole hand. We will now pass the sutures and draw somewhat upon the posterior wall, through which it passes, and you will find that the vagina shortens, the uterus comes nearer to the introitus, and as the cervix is drawn slightly forward, the fundus leans backwards. Draw the suture still more and fix it with a firm knot, and on now passing your index finger you will easily meet the cervix at its tip, and the fundus will have been thrown still a

little further backward into what we would call a normal position. This series of facts I have demonstrated to myself on the living subject, and it serves to establish the ease with which a uterus may become prolapsed and afterwards retroverted, as it sinks in the pelvis where the perineum and vaginal wall have not been repaired, and the patient soon assumes the erect posture. I will now, by this wooden model, show how the suture is passed, and illustrate that it thoroughly controls the muscles in the perineum (the transversus perinei, bulbo-cavernosus, &c.) which exert any traction power on the laceration. This is independent altogether of the fact that as the child becomes evolved, dilatation is so extreme that there is such calibre to spare between this extreme dilatation and complete involution, that there can be practically no side traction upon the wound till the eighth or tenth day, when union will have become fairly strong. So that really all we want are two fixed points—one at each extremity of the wound—and that the cavity of the wound be cut completely off from the vagina (the drain-pipe to the uterus). Draw the suture tight and tie the vent, pass your forefinger down along the posterior wall of the vagina, and you will find no wound, not even a fissure. The whole laceration is compressed like the mouth of a bag by a running string. The wound below is a *cul-de-sac.* The sides are in perfect contact, and as no discharges from the vagina can possibly enter it, primary union must ensue.

Dr. Kennedy said slight tears were very common, and seldom could be avoided. These tears appear more at the time, and almost always do well without interference. In an instrumental case, there is much less danger of a bad tear if the forceps be removed when the head is well down against the perineum, allowing the natural efforts to complete delivery. He advocated stitching if there be much of a tear. Unless there were special danger of septic poisoning, he would not use injections.

Dr. Blackader dissented from Dr. Kennedy in leaving even a very moderate tear alone. He always mends such a rent for two reasons. It lessens the chance to prolapse, and it closes an open wound, thereby guarding against septic infection. Here-

tofore he has put in two or three stitches; lately he has tried the single stitch, as employed by Dr. Alloway, and with good results.

Dr. Trenholme believed a common darning needle would answer in this operation. He said that after a day or so the stitch got loose from the tissues being swollen when applied; to obviate this, Dr. Carson of Detroit employed the shotted suture —that is, a wire suture held on each side of the rent by a small bullet which could be pushed up the wire when it became loose. He (Dr. T.) uses the catgut sutures, and gets perfect satisfaction. He thought Dr. Alloway's purse-string suture would shorten the posterior wall of the vagina, and so favor prolapse and retroversion.

Dr. Roddick said that Dr. Alloway's operation had this in its favor—it was easily done. He believed it to be an admirable method.

Dr. Gardner had not yet tried the single stitch. He employs two or three stitches of silk. He intended trying the single ligature.

Dr. Alloway, in reply, said that Dr. Kennedy's cases, where left alone, had to heal by granulation, not by first intention, as is the case when stitched properly. In reply to Dr. Trenholme, he said that a common darning needle would be very apt to break in the forceps. As to Dr. Carson's shotted suture, he thought it very objectionable to be interfering with the wound every day. Catgut sutures are difficult to tie, and they may become absorbed too soon.

Dr. Kennedy asked what length of tear Dr. Alloway would consider necessary to stitch.

Dr. Alloway said anything over a quarter of an inch.

Stated Meeting, March 6th, 1885.

T. G. Roddick, M.D., President, in the Chair.

Congenital Looseness of all the Joints.—The President exhibited a girl aged 4 years presenting this condition and allowing of the production of partial dislocation of all the larger joints. Talipes of the feet could also be simulated.

Decidual Cast of the Uterus.—Dr. Alloway exhibited a very perfect decidual cast of the uterus at the end of the sixth week of gestation.

Neuroma.—The President shewed a neuroma dissected from an amputated stump.

Dr. Hingston said he believed that the bulbous end of a nerve was a frequent cause of pain in the stump, and related a case in illustration.

Case of Pulsating Empyema.—Dr. Geo. Ross read the following paper on this case:—

G. W., æt. 37, express-driver, was admitted into the Montreal General Hospital on the 29th December, 1884, suffering from sharp pain in the left side, a short cough, and feverishness. Two of his brothers have died of phthisis. He himself has always been a strong and healthy fellow. Had pneumonia five years ago, with which he was in bed for three months. Never had rheumatism nor syphilis, and has never been affected with thoracic pain or shortness of breath.

His present attack began on the 24th December, when he got a severe wetting, and did not feel very well. Was drinking a good deal at the time. On the 26th he had a chill, followed by sudden stabbing pain in the left side. Took to bed the same day, and had a short, hacking cough, with slight expectoration.

On admission.—Patient is a strong, able man, of good muscular development. Face flushed, with dilated venules. Skin hot and dry. Herpetic eruption on lips. Pain is much complained of, situated in the left lower axillary region, considerably increased on inspiration and by pressure over the same part.

Cough short, and accompanied by pain and expectoration, which is of a glairy, mucous character. Temperature 103° at night. Pulse 120, small and weak. Respirations 24, short and shallow. Tongue moist and coated.

Examination shows somewhat deficient expansion upon the left side. Dulness on percussion at the left base, where the respiratory murmur is weak and accompanied by a few crackling râles. Resonance and fremitus diminished in the same area. Heart sounds are feeble, and free from murmur. The urine contains a heavy deposit of lithates ; no albumen.

The patient continued in much the same condition for several days, the temperature pretty high, and the pulse always above 120. The pain only slightly diminished. On the 2nd January, the note gives dulness to angle of scapula and through lower axillary region. During the following week he suffered a great deal of pain in the left side, not specially confined to the lateral region, as before, and more continuous, preventing him from sleeping, and making him look feeble and exhausted. The fever still remained, and he inclined to sweat a good deal.

I did not see him during this time, but re-examined him on January 8th, when the following notes were made : The dulness in the lower areas of the left side much less. On percussing the front of the chest, a flat note is found commencing at the upper margin of the second left costal cartilage, and continuous with that of the heart. This dull area is bounded externally by a line drawn through the nipple, and it passes as well directly across the sternum and to a finger's-breadth to the right of this bone. The expansion movement of the left front is much impaired ; the second and third intercostal spaces are observed to be prominent, and to present a quite perceptible pulsation, synchronous with the systole of the heart. On palpation, the pulsations are felt quite strongly. Resonance and fremitus much diminished. The vesicular murmur is almost absent in the dull area, and is found, moreover, to be markedly enfeebled throughout the whole left lung.

During the two weeks following, the case appeared to be stationary. The temperature fluctuated somewhat, but was always

above normal. He sweated a good deal, and emaciated considerably. The pain was persistent, and rendered intolerable by any attempt to lie upon the left side. The physical signs were those last described.

On the 22nd January, a rough friction-sound was heard along the right margin of the sternum, from near the clavicle to the third rib. At this time he had increased fever, with nausea and vomiting; and on this and the following day the pain was more especially complained of about the dull region under the left clavicle.

On the night of the 2nd February he had a severe fit of coughing (having had but little cough for some days previously), which was immediately followed by the out-flow of a good pint of pure pus. This was thick and creamy, and had no ill-odour. The whole of it was brought up in a few minutes. When seen the next morning, he had a loose cough, every effort serving to bring up a large mouthful of pus. In this way half a pint or more was expectorated during the day. The percussion-note of the previously dull area at once changed to a clear and somewhat tympanitic note. The pulsating tumor had entirely disappeared. The breathing was cavernous, and accompanied by bubbling râles. The respiratory murmur throughout the left lung has become stronger.

A loose cough, with some purulent expectoration, continued for a few days, and then ceased entirely. The temperature fell at once to normal, and has there remained. The percussion quickly became pulmonary in quality, the respiratory murmur was re-established everywhere, and the râles disappeared. Sleep and appetite soon returned, and on the 2nd March the patient left the hospital strong and well.

Remarks.—From the history of this case, as above detailed, it is sufficiently evident that a considerable collection of pus was formed in the upper part of the chest, upon the left side, as a result of an acute pleuritic inflammation. That this localized empyema was so situated that it communicated very distinct pulsations either from the heart itself or from the aorta to the surface of the thorax. That it subsequently opened and dis-

charged itself through the air-passages, thus allowing the corresponding lung to entirely re-expand. That thus a complete and spontaneous cure was brought about. It will have been noticed that evidence of the early stages of the pleurisy—friction-murmur—in the situation later occupied by the effusion was not observed. This probably arose from the fact of attention having been directed to the base of the lung, where the trouble seemed to be entirely located at the commencement. When I re-examined the patient myself on the 8th January, I discovered the very striking physical signs which have been mentioned. One can hardly fail to be struck with the remarkable similarity between this collection of signs and those so frequently met with from an aneurism of the thoracic aorta—viz., localized well-defined dull area to one side of and beneath the upper portion of the sternum, prominence of the spaces, and, above all, pulsations very distinct and easily both seen and felt. Moreover, very decided enfeeblement of the respiratory murmur in every region of the left lung. The case was therefore reviewed with the idea of this possibility borne in mind. There was no bruit, there was no intensification of the second sound (the more important, diagnostically, of the two), there was no fulness or palpable pulsation behind the manubrium, there was no downward traction upon the trachea. These points decided, I thought positively, against aneurism. Moreover, the clinical history of the patient previous to his present acute attack was entirely negative as regarded the usual subjective symptoms of thoracic aneurism. We had, too, the very best reasons for believing that, on his admission, no such physical signs were present, as he had been examined by my house physician and by an experienced clinical clerk. The combined dulness, enfeebled breathing and diminished fremitus accompanying and following upon the evidences of inflammatory action plainly declared by the continued pain and marked febrile disturbance—all pointed to the presence of fluid, and probably purulent fluid. The pulsation, of course, was a very unusual feature in the case, but that this occasionally is produced through purulent effusions we all very well know. The observation which I found most difficult

to explain was the decided obscuration of the vesicular murmur throughout the entire lung. The percussion-note was not obviously altered from that of the opposite side, except at the extreme base, where a small effusion was rapidly disappearing; and the conclusion was inevitable that the absence of tidal air must be explained by the existence of pressure upon the main bronchus. I have never before met with this condition as a result of an advancing collection of fluid. On the other hand, how common it is to find it brought about by the advancing pressure of a growing neoplasm or aneurismal tumor. Although, therefore, we had good reason to look upon the local trouble as probably an empyema, I thought that the possible existence of some obscure neoplasm (not an aneurism) was not to be lost sight of, as, perhaps, complicating the case. A few days later, the occurrence of loud frictions to the right of the sternum proved the existence of continued inflammation of the serous membrane. The happy termination of the case you already know; and the fact that, after spontaneous evacuation of the purulent collection, the left lung responded completely, with resonance and tidal wave unimpaired, showed conclusively that the entire set of symptoms and physical signs had been produced by a localized empyema.

Empyema is a sufficiently common condition, and we all meet with many examples of it, occurring under a great variety of circumstances, in the course of our regular practice, but, although these collections are quite frequently situated upon the left side, yet it is very rarely indeed that the pulsations of the heart or great vessels are communicated through the purulent fluid. Rare, however, as such cases undoubtedly are, they must nevertheless be borne in mind, for they are apt to simulate aneurism, and cause errors in diagnosis. In the majority of instances, the situation and extent of the dull area will be such as to offer no difficulties of the kind, but in cases like the one I have described, the physical signs are accurately limited to just such an area as might be occupied by an aneurismal tumor. If this patient had been seen for the first time on January 8th, and with an imperfect clinical history, it might have required very careful

examination and the employment of the method of exclusion in order to arrive at a correct opinion.

This symptom has been known for a long time. Fraentzel (Ziemssen's Cycl.) quotes the expressions of an old writer, Le Roy, to prove this. "When, with these indications (of empyema) which we have given, a troublesome beating arises in a certain part of the chest, we must not hastily conclude that an aneurism is present." "When the collection of pus is so placed that the action of the heart or of the great blood-vessels makes an impression upon it, there sometimes arises the false appearance of an aneurism."

I think that in this case the pulsations observed were communicated from the aorta. This vessel, being filled by each successive systole, would necessarily compress any sac of fluid in immediate contact with it and, if the latter touched the thoracic parietes, cause visible projections upon the surface. On the other hand, when pulsations are observed in the side of the chest, from the heart itself, these must be produced by the lateral movement of the heart from right to left during the systole; because, with contraction, the heart does not increase in bulk, and could not, therefore, produce compression of an adjacent body of fluid. The full explanation of these communicated pulsations is an interesting subject, and one on which but very little that is satisfactory is to be found in medical literature.

Dr. Hingston said that when a student, in 1851, at the General Hospital, he saw a case of pulsating empyema, accompanied with metallic tinkling synchronous with the pulse, and evident at the surface of the back. The late Dr. Holmes, then clinical teacher, said at the time that it was the first case of the kind he had ever seen.

Dr. Geo. Ross did not see how you could possibly have pulsation communicated through the fluid in a case of pyo-pneuthorax. The physical conditions which would cause amphoric phenomena would prevent pulsation being observed. To observe the latter, the sac must contain fluid alone.

Cases in Practice.—Dr. Shepherd related the peculiar abnormalities seen by him lately in a healthy young man aged 22,

who has transposition of the viscera of the chest and abdomen. The right testicle hangs lower than the left.

Stated Meeting, March 20th, 1885.

T. G. Roddick, M.D., President, in the Chair.

Dr. A. L. Smith shewed the following cases of skin diseases: 1st, *Tinea Tonsurans* in a state of kerion, the ulcerating patch being about $3\frac{1}{2}$ inches in diameter. 2nd, *Specific Lupus of the face;* the patient, a woman, was doing well under applications of acid nitrate of mercury. 3rd, *Specific ulceration* on the leg of the last patient's husband. 4th, *Tinea Versicolor* over the chest of a delicate young woman.

Case of Abdominal Section.—Dr. Trenholme, who performed the operation, said this case was of some interest, inasmuch as a definite diagnosis was not only impossible before the operation, but the portions of the tumor removed, and now before the Society, have not yet been definitely determined as to whether they are the remnants of an extra-uterine fœtation or of a dermoid cyst. A report upon their character will be brought before the Society at a subsequent meeting. The following are brief notes of the case:—

The patient, Mrs. O., of Ontario, a well-developed, fleshy woman, 46 years old, was married 31 years; no children. One abortion 25 years ago. For nine years after abortion, suffered at menstruation. Twelve years ago had inflammation of the bowels. Ten years ago had another attack of a similar character. After this, enjoyed fair health till change of life occurred, seven years ago. Since this last period, was pretty well up to October last, when she had what was supposed to be inflammation of the bowels. Her health from this time onward not good, when, about the beginning of the present year, she was again taken ill with very severe inflammation of bowels, though, she said, the disease seemed lower down in her body, accompanied with a good deal of irritation of the bladder and decrease of quantity of urine. Menstruation returned again last fall, but was scanty

and at irregular intervals also, frequently accompanied by severe pains. *Present state.*—Debilitated appearance, pasty color; irritable stomach; scanty urine (2 or 3 ozs.), high-colored, no albumen; bowels regular; pulse weak (shabby) and rapid. Tumor felt over hypogastrium; per vaginam, tumor over brim of pelvis, larger than a fœtal head. Uterus 2¼ in., and carried upward and backward. Tumor and uterus found closely united, but thought moveable. Diagnosis, fibro-cystic tumor of uterus most favored, but held to possibility of tumor being ovarian. *Operation.*—Assisted by Drs. Hingston, Kennedy, Perrigo, and Armstrong, made usual exploratory incision, and found no walls to cyst. Removed three gals. of fluid, and then found the debris of a dead fœtus, which, with the placental debris, was scooped out with the hand. No ligatures were required to arrest bleeding, which was very slight. Abdominal cavity was well cleaned and washed out. Uterus and ovaries were normal. *Result.*—Patient never overcame the shock, and died twenty-two hours after operation. No post-mortem was permitted.

In reply to questions, Dr. Trenholme said the woman's history did not indicate pregnancy, and that before operating her temperature was normal.

Several members who examined the debris gave it as their opinion that there were no fœtal structures present. The bony piece was thought to be part of an ossified cyst wall. There was no sign of any of the long bones.

Sarcoma of the Testis.—The President exhibited the specimen and related the following history of the case: Patient, aged 48, had an attack of orchitis first in September, 1883; no cause could be assigned for this. He rode much on horseback in the woods, but there was no history of injury. In July '84, he had another attack of inflammation in that testicle, which did not reduce in size. Last October it became very bulky. There was no disease in the cord. He was anæmic. No history of syphilis. Had had gonorrhœa ten years ago. Iodide of potassium and mercury was given for a month. After this, Dr. Bell attended him through an attack of phlebitis of the left leg. Sarcoma of the right testicle was diagnosed. Dr. Roddick removed

it, and a microscopic examination revealed it to be of the large round-celled variety of sarcoma. The tumor was as large as the fist. Slides prepared by Dr. Wilkins were shown under the microscope.

Large Intra-uterine Myoma.—Dr. Wm. Gardner exhibited the specimen and related the case. Patient, aged 42, very pale, came to him with a history of severe hemorrhages for the past two or three years. No pain. An examination caused a great hemorrhage. The tumor could easily be felt in the hypogastrium, and by the vagina, in the uterus. After dilating well with tents, it was removed in pieces by means of the spoon saw. The operation lasted an hour and a half. Not more than five or six ounces of blood was lost. A good many shreds came away after. The uterus was thoroughly irrigated and drained with the double tubes. These were sutured to the lips so as to keep them in place. After eight days they ulcerated away, and were allowed to remain out for 24 hours, when the temperature rose to $101\frac{1}{2}°$. The os was then opened, and three or four ounces of bloody fluid escaped. The tubes were again used as before. The patient made a good recovery. Dr. Gardner said that the irrigation was troublesome, but on it rests the success of the operation. Lawson Tait has lost 50 per cent. of these cases.

Dr. Trenholme said he had removed several of these tumors and never lost a case.

Dr. Smith asked if ergot had been given in this case for a long time as recommended.

Dr. Gardner replied that the patient's history and blanched condition indicated immediate operation. Ergot could not be depended upon, and, besides, the woman was poor and could not afford to lie up.

The President thought the woman's condition justified operative interference.

Removal of a Uterine Myoma with the Cephalotribe.—Dr. Hingston said that two weeks ago a lady came to him from the country suffering greatly from a large uterine myoma, which did not cause hemorrhage. The tumor was about the size of an infant's head, and sessile. He had seen Sir James Simpson use

the cephalotribe in a similar case, so thought he would try it here. One blade was easily entered, but much coaxing was required to get in the other. A good bite was secured, and the screw applied. In this way one-half came away. Again the blades were applied, and half the remainder came away. Now the uterus was drawn down and out, and the rest of the tumor shelled out with the fingers. Patient made a good recovery. Injections of Condy's fluid were used.

Dr. Gardner said he believed the vulsellum and spoon were the best instruments to use in these cases.

Dr. Trenholme remarked that both in this case and Dr. Gardner's an incision through the mucous membrane covering the tumor might have been all that was needed, as this simple operation has at times relieved pain and arrested hemorrhage.

Dr. Shepherd read a paper on "*The Musculus Sternalis and its occurrence in Anencephalous Monsters.*" He stated that the musculus sternalis was a supernumerary muscle which has always excited a great deal of interest among anatomists, and that its proper morphological significance was not yet fully determined. It was seen in about three or four per cent. of ordinary individuals, and its fibres generally ran at right angles and superficial to the great pectoral. It was often bilateral but most frequently unilateral, and was subject to many variations. Frequently it had no attachment to bone, but lay superficial to the great pectoral and was attached at either end to fascia. It often was inserted into the costal cartilages. It might be continuous above with the sternal origin of the sterno-mastoid, and below with the fascia of the external abdominal oblique. Again, it might be continuous with the pectoralis major, and be associated with deficiency of that muscle. It was often of small size, but occasionally it was quite a strong muscle, and could be seen under the skin in the living. Dr. Shepherd had seen it measuring five inches long, two and a half inches broad, and two and a half inches thick. For years it was considered to be a remnant of the rectus abdominis, which in many animals extends from the pubis to the top of the sternum, and was called the *sternalis brutorum*. This view

had long ago been given up because the rectus abdominis lies in a plane deeper than the great pectoral, and is never superficial to it. Bourienne many years ago held that it was a prolongation downwards of the sterno-mastoid, a view still held by Henle and others. Hallett and Wilde regarded it as belonging to the same group of muscles as the platysma, and Prof. Turner, of Edinburgh, considered it to be one of the representatives in man of the great panniculus group which exists in most mammals. Darwin also held this view in his work on the *Descent of Man*. After referring to the views of Prof. Halbertsma, M. Testut and Prof. Bardeleben,

Dr. Shepherd stated that Prof. Cunningham, of Dublin, has lately in five cases traced the nerve supply of the musculus sternalis to the anterior thoracic nerve, and that he, believing that the nerve supply was the best indication for the proper classification of muscles, considered that the musculus sternalis belonged to the pectoral group. Prof. Cunningham also suggested that this was a new inspiratory muscle appearing in man, and that it was his impression that it occurred more frequently in females, due possibly to costal inspiration being more pronounced in them. Mr. Abraham, of Dublin, first pointed out, last year, that this muscle was very common in anencephalous monsters, as he had found it in six out of eleven specimens examined. Mr. Abraham looked upon it as probably an aberrant portion of the great pectoral muscle.

Dr. Shepherd said that he had examined six anencephalous monsters which were in the museum of the Medical School of McGill University, and wished to place the results of his dissection before the Society. In each monster he had found a well-developed musculus sternalis. In three the muscle was double ; in two continuous above with the sterno-mastoid, and in several it arose from the manubrium sterni and was inserted into the costal cartilages. In all the cases there was a deficiency of the great pectoral muscle on the side where the supernumerary muscle was found, the abnormal muscle apparently taking the place of the absent portion of the pectoral. In several the muscle was of large size, and in part continuous

with the fibres of the great pectoral. Nine muscles, in all, were found in six monsters, as three had double muscles. Dr. Shepherd had successfully traced the nerve supply of these muscles in all but two—that is, seven of the muscles were supplied by the anterior thoracic nerve; the nerve entered the muscle in its deep surface and could be traced back over the lesser pectoral through the costo-coracoid membrane to the internal anterior thoracic nerve.

Dr. Shepherd remarked that it was a curious fact that this muscle should be supplied by a nerve which is at so great a distance from it, and not by the intercostal nerve, which in several cases pierced the abnormal muscle without giving any branches to it. He also stated that he had formerly held that the *musculus sternalis* belonged to the panniculus group, but that these dissections had caused him to alter entirely his previous views as to its homology, and that now he had little doubt that this muscle belcnged to the pectoral group because: 1. Its nerve supply. 2. When present the great pectoral is generally deficient. 3. Its continuity in many cases with the great pectoral. 4. That it was in the same muscular plane as the great pectoral. Dr. Shepherd said that it was his belief that the nerve supply was the best guide we possessed for determining the homology of a muscle.

Dr. Shepherd was unable to explain why this muscle should be so common in anencephalous monsters, except that in these undeveloped beings there was a greater tendency to revert to previous conditions; but he said it was difficult to reconcile the fact that this muscle was an aberrant portion of the great pectoral and a reversion to some preëxisting muscle, as no known existing arrangement of the pectoral group in the lower animals at all resembles the condition found in these monsters. He also stated that if this muscle was an aberrant portion of the great pectoral which had no animal representative, then Prof. Cunningham's theory that it was a new muscle appearing in man had some degree of probability. Dr. Shepherd said he was not prepared to accept this explanation, but awaited further light and further knowledge of comparative anatomy before

pronouncing definitely on the morphological significance of the musculus sternalis.

After the reading of the paper, the specimens were exhibited to the Society.

Dr. Henry Howard said that Dr. Shepherd's demonstration was a further proof that man evolved from a lower animal, and did away with the theory of the creation of man as he now is.

Stated Meeting, April 3rd, 1885.

E. H. Trenholme, M.D., 2nd Vice-President, in the Chair.

Dr. Stewart exhibited the patient, and read the following account of a case of *Tabes Dorsalis* with exaggerated patellar reflex :—

The patient (a man), who is 42 years of age, complains of dimness of vision, flatulency, and of shooting pains in various parts of his body. He dates his troubles to a "cold" which he contracted three years ago. Among the first symptoms he noticed were the darting pains which have troubled him with more or less severity ever since. Two and one-half years ago he suddenly became aware that he saw objects double, and on shutting his right eye he was surprised to find that the vision of his left was markedly diminished. This diminution in the vision of the left eye steadily progressed until a few months ago, since which it has remained stationary. During the past five or six months there has been a steady and progressive diminution in the vision of his right also. He injured his back a few years ago, but neither at the time nor afterwards does it appear that he suffered in any particular way from this injury. In 1875 he had two sores on his penis, but there is no positive evidence whatever that those sores were of an infecting character; otherwise, his past history was unimportant. There is nothing of importance to be derived from the family history.

His present condition is as follows :—There is no paralysis or atrophy of any of the voluntary muscles—their mechanical,

faradic and galvanic irritability are normal. All the superficial reflexes are more or less exaggerated with the exception of the plantar. The cremasteric reflex is especially exaggerated. The patellar reflexes are exaggerated, as are also the triceps reflexes, but only to a slight extent compared with the patellar. The organic functions of defecation and micturition are considerably interfered with, while the swallowing reflex is normal. Shortly after urinating he is able, by "pressing hard," to pass a number of ounces of urine. That the sphincter of the bladder suffers as well as the detrusor is shown by the fact that when the desire to urinate comes on, unless he is ready, the urine floats away in spite of all his voluntary efforts to retain it. Although not troubled with constipation, he has difficulty in expelling the contents of the rectum. The "shooting pains" which trouble him are, for the most part, situated in the lower extremities. Sometimes, however, they have their seat in the hands, arms, trunk, face, neck, and even the ears. He has no delayed sensations, but he frequently experiences a sensation as if some one was pinching him or pulling from within outwards—a pain through his skin. There is no inco-ordination or disturbance of the muscular sense.

Dr. Buller's report of the condition of the eyes:—"Argyl-Robertson Pupil.—There is a very considerable atrophy of both optic nerves, with great limitation of the visual fields, especially of the left. The nerves are pale and of a blue-gray color. The blood-vessels are very small. There is no evidence of a previous inflammatory condition." The functions of the remaining cranial nerves are normal.

Dr. STEWART remarked that there was no doubt that the man was suffering from tabes dorsalis, despite the fact of the marked exaggeration of the patellar reflexes. There were present two of the three characteristic symptoms of this disease—the lightning pains and the reflex immobility. In addition there was the optic nerve atrophy, the temporary diplopia, together with the bladder and rectal symptoms, forming a combination of symptoms that, at least up to the present, have only been described under the head of that myriad-sided disease, tabes

dorsalis. Absence of the patellar reflex, Dr. Stewart remarked, is looked upon as one of the most important and earlier symptoms of the disease. A few cases have been recorded where it has not been absent, but up to the present time he had not read of any case where it was exaggerated. On theoretical grounds it had been suspected that, preceding the stage of loss of patellar reflex in the tabes, there is a period when it is exaggerated. Even were this supposition true, it would not aid us at all in this case, for it is one of considerable standing, although still in the pre-ataxic stage. The increased reflexes cannot be explained by disease of the lateral column, for there is an entire absence of any increased tonicity, this symptom being, next to the exaggerated reflexes, the most trustworthy evidence of a sclerosing of the pyramidal strands. Dr. Stewart concluded by stating that the honor of having made the diagnosis was Dr. Buller's, and it was owing to Dr. Buller's kindness that he was enabled to present him to the Society.

Dr. Henry Howard said that the expectation of mental symptoms depended on whether the lesion begins high or low in the cerebro-spinal system, for in descending lesion death takes place before any dementia occurs. Hence, the important point is to know what centres are affected, and whether these be above or below the reflex centres usually implicated in tabes. Here it is interesting that the cortical substance having been involved some years, there is yet no impairment of mental powers.

Dr. Campbell said that owing to the better knowledge in general, and especially of ophthalmoscopic signs, cases of this disease were now detected which formerly escaped diagnosis; but he did not believe such cases occurred with greater frequency to-day. He spoke of a case (which had been seen in consultation), by Dr. Trenholme, in which a woman evidenced exaggerated sexual desire, and subsequently became insane.

In answer to Dr. Trenholme, Dr. Stewart said death was often due to exhaustion from the pains.

Dr. H. Howard said that pneumonia was sometimes a cause of death, due to implication of pulmonary trophic centres and respiratory tract.

In answer to questions as to treatment, Dr. STEWART said though there was little evidence of syphilis, he had put his patient on anti-syphilitic treatment. Electricity is useful to control the pains. The flatulence was thought part of the disease, due to paresis of intestinal muscles.

Some discussion as to the use of ergot in tabes followed, and Seguin and Althaus were quoted in support of its use. Dr. STEWART said that it was perhaps dangerous, as ergotism caused an apparently genuine tabes.

In reply to questions as to etiology, Dr. STEWART said symptoms, especially eye symptoms, no doubt preceded injury and heat, etc., referred to.

Dr. REED called attention to disturbances in the function of urination as early symptoms in tabes.

Dr. REED spoke of *second attacks of measles* in same patient, and spoke of two such recently observed by him.

Dr. CAMPBELL said he had seen at least six such cases, and, much more extraordinary, had seen scarlet fever recur within a few weeks of first attack. He also spoke of the severity of the complications in the present epidemic of measles, as pneumonia, pleurisy, etc.

Dr. KENNEDY followed to same effect, and cited a case where scarlet fever, measles and whooping-cough were interchanged among the children of one family. Dr. Kennedy also spoke of a case where he diagnosed measles ten days before the development of rash, owing to catarrhal symptoms and a prodromal rash.

Dr. CAMPBELL spoke of whooping-cough frequently following measles in this epidemic. He advised treatment with quinine, with cures *in every case* within five or six weeks. He said the theory was that the spores deposited on fauces kept up irritation, and the quinine by causing profuse secretion led to these germs being washed away. This being the theory, the practical point is that the treatment by quinine is very successful.

Dr. REED said that Henoch found that "the measles usually followed whooping-cough, and that quinine had failed in his hands, he finding morphia most efficient."

Dr. TRENHOLME said that, in his hands, Drosera Rotundifolia (Parke D. Extr.) and Eucalyptus had done good service in whooping-cough.

Stated Meeting, April 17th, 1885.

E. H. TRENHOLME, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

Tubercular Lung with Pleura from a case of Hydropneumothorax.—RR. R. J. B. HOWARD exhibited the specimen, and said that on opening the thorax the right lung was emphysematous and contained many grey granulations about the anterior part of middle lobe. Left pleural cavity contained a blood-clot measuring 17 oz.; on removing this, the pleural sac was everywhere lined by firm buff-colored membrane nearly a ¼-inch thick. The pulmonary portion was equally thick, and bound the lung firmly down to the vertebral column. A small opening communicated with a cavity in the lung, this opening being situated high up behind. So firmly attached was the lung that it had to be cut out; in doing this the cavity was opened. It occupied the whole upper lobe, and would have held a hen's egg. Its walls were lined in the upper part by a smooth, grey membrane, but the larger part of the walls were ragged and crossed in all directions by strands of tissue, in many cases consisting only of one or two vessels of considerable size. The cavity contained a good-sized clot. No open vessel was found. The lower lobe contained many caseous nodules. Evidently the cause of death was hemorrhage from the pulmonary cavity into the pleural space—in fact, internal hemorrhage, a very unusual termination. The patient had had pneumothorax for months, and his chest was opened and drained about two weeks before. There was more fear that the operation might have caused, or at least accelerated death, but he could find nothing to lend color to this view—in fact, the obliteration of the pleural cavity from the bottom was commencing.

DR. GEO. ROSS said he had first seen this patient about 18 months ago, but that he had been in the hospital previously for

months with phthisis and softening of the left apex. The day before seeing him he had been seized with severe pain in the left side, accompanied with shortness of breath and distress. This continued for 24 hours. On examining, pneumothorax was found, but there was no fluid. The left chest was distended with air, the heart pushed over, pulse rapid, and he was cyanotic. After a time fluid gradually replaced the air till the left side was full. Was then tapped and serous fluid removed, giving great relief and feeling much better. Went home, where he improved and gained weight. He came to the hospital once a month to be examined. After some months the chest again refilled and he became feverish. He was again tapped, a sero-purulent fluid coming away. The fluid rapidly re-collected, accompanied with fever and emaciation. An incision between the ribs was made by Dr. Shepherd and a drainage tube put in. The fever lessened, though some remained. The pulse was still rapid. He was improving, till one day he suddenly became pale and exhausted, and blood leaked out by the tube. But for this accidental ulceration of the vessel in the lung he thought this patient might have recovered. A similar case had been treated by Dr. Wilkins and himself ten years ago, who recovered, and is now alive.

Dr. Kennedy said that this case recalled one he had seen years ago, that of a man who died from fracture of the skull. At the post-mortem the right lung was found collapsed and in a fibroid condition, the side of chest sunken in, and the viscera had adapted themselves to the altered shape of the chest. The organs appeared healthy, and the man would have lived years but for this accident. He had been operated on for pyothorax two years previously.

Dr. Godfrey said he had seen a similar case where a woman died seven years after from tuberculosis of the opposite lung.

Pieces of Necrosed Bone from an Abscess at site of Potts' Curvature.—Dr. Shepherd exhibited eight small bits of bone removed by him from an abscess at the side of the spine. A second abscess was on the side—both following inflammation produced by a kick over the part.

Antiseptic Midwifery.—Dr. Armstrong read the following paper on this subject:

That Sir Joseph Lister has done a great deal for surgery—by enlarging the field of justifiable operations and by rendering the results of all operations more satisfactory—none will deny. But to what extent the details of his method of operating are essential there is still a wide difference of opinion; and even the soundness of the theory upon which his practice is based may be safely questioned. Indeed there is a suspicion among not a few that, after all, we may find in the future the lesson to be learned from the practice of Lister is that absolute cleanliness of the part operated, upon the part of the operator, and of instruments used in the operation, *is the great essential of success*, and the thanks of the profession to Joseph Lister should be none the less profound, because his labors have been none the less effective if the suspicion should prove to be correct. The germ theory is the fashionable way of accounting for many of the accidents of surgery, as well as for the presence among us of many diseases. Lest we again lay ourselves open to the charge, sometimes laid against us by the lay press, of allowing ourselves to be led to one extreme by some prominent professor with an unpronouncable name, and then in a short time following some other leader as blindly to the other extreme, let us pause and examine some of the facts of familiar occurrence in every-day life, and ascertain whether or not they are in harmony with the theory advanced.

Antiseptic surgery is based on the theory that the atmosphere which we breathe and by which we are surrounded contains germs which, when allowed to come in contact with wounds, are capable of lighting up unhealthy action in them; and this theory has been more and more widely applied, until now, by some, it is taught that the physiological action of child-birth should always be conducted on what are known as strictly antiseptic principles, and it is this somewhat new application of the germ theory that I purpose briefly to discuss this evening.

Do our parturient patients whom we attend in confinement in the ordinary way, without the use of any antiseptic dressings or

douches, and without any special previous cleansing or disinfection of their apartments, present, as a rule, symptoms of septic inoculation? So far as my experience goes, the answer is decidedly in the negative. If I am not much mistaken, it is the exception for men who do a large midwifery practice among the middle and lower classes to have cases of septic poisoning occurring among their parturient women. We younger men are often called to attend women in their confinement whom we see for the first time when they are in labor,—women who live in unhealthy, low, badly-drained localities, and in houses not overclean and ill-ventilated—women whose surroundings are eminently adapted to favor the growth and spread of atmospheric germs, and yet even among these I believe it is comparatively rare to have trouble of a septic character. Now if a man confines 100 women, and 98 of them make perfect recoveries and two of them present symptoms of septic poisoning, should he blame any one of the many surroundings common to them all as air, or should he look for some extraordinary agent to account for the evil. The experiences of ages and all medical literature teaches the latter. We constantly hear and read of septic cases due to a portion of decomposing placenta or membrane or blood-clot remaining in the uterus or vagina, or cases that can easily be traced to contagion carried by the accoucheur. Now, is it possible for the strictest antiseptic precautions to prevent the occurrence of septic infection of women during and after their confinement? Let us suppose, for instance, that we have had apartments to be occupied by our patient newly whitewashed and papered and disinfected, and the bed, bedding and napkins and all the clothes to be used by the patient thoroughly carbolized or sublimated, is our patient then safe? I fear not, unless the accoucheur and nurse themselves see to it that they neither touch nor enter the presence of any unclean thing. If the doctor comes from examining a child with diphtheria, or a patient with erysipelas, and enters that chamber and touches the patient or the napkins, he unavoidably communicates the poisons to the patient or to the napkins and the napkins to the patient. I think I cannot better illustrate not only the *possibility*, but the *proba-*

bility of such a sequence of events than by quoting an account of similar occurrences from the latest edition of Emmet's "Principles and Practice of Gynæcology." On pages 717 and 718 of this work Emmet relates the two following cases. In the first one Dr. Emmet was about to remove a small ovarian cyst from a young girl in apparently perfect health. Dr. Emmet says: "The sponges, instruments and ligatures had been prepared with unusual care, and I never performed an operation where there seemed so little liability for any complication to occur." Just before the operation several physicians from the Polyclinic or Post-Graduate Medical School sent in cards of introduction from some of the staff, requesting that they might witness the operation, and they were admitted. Just as the doctor was commencing the operation one of these gentlemen picked up a pair of forceps or scissors from the tray to show a friend alongside. Emmet caught his hand, requested that he would not touch the instruments, and then went on with the operation, neglecting to disinfect the hand that had touched the gentleman's coat. In less than twenty-four hours, the report says, the girl was doomed, and died on the sixth or seventh day. It was found at the autopsy that an abscess had formed, extending from the wound and around the pedicle, and that the girl died of septic peritonitis. Emmet adds that the man who picked up the instrument was responsible for the girl's death.

The other case is that of a woman suffering from procidentia, sent to Dr. Emmet for treatment by Dr. A. Jacobs. At the operation, after Dr. Emmet had denuded a large surface, Dr. Jacobs, who was present, placed his finger upon the prolapsed surface to satisfy himself that it was unusually hard. Two days after the operation, the patient's temperature was found to be 105°. Upon removal of the sutures, the whole surface which had been freshened was found covered with a diphtheritic deposit as thick as a piece of chamois leather. It was ascertained that Dr. Jacobs had examined the throat of a child suffering from diphtheria early that morning. The operator had not seen a case for years; Dr. Bache Emmet, the assistant, had not in six months. The nurses were out of the way of meeting the disease,

and the patient had not been out of the house for several weeks. Now the two points I would make here are:

1st, How remarkably easily septic matter is conveyed. From what we know of the properties of septic matter, it does seem that, if the air is full of them, all wounds exposed to the atmosphere pressing these germs against exposed surfaces with a pressure of 15 lbs. to the square inch should become infected; yet we know from experience that this is not the case, and the fact that this is not the case is good evidence that the atmosphere ordinarily does not contain them. That wounds heal kindly and by first intention, and that women are confined every day without any septic trouble supervening, and without the so-called antiseptic precautions being taken, certainly proves this much, that the so-called antiseptic precautions are not essential to perfect healing of the parts after an operation or to perfect recoveries after confinement.

2nd, That, in spite of all possible antiseptic precautions, one touch from a known and well-defined source of contagion renders all our antiseptic preparations useless.

May not the question be fairly asked: If all the known and well-defined sources of contagion are strictly guarded against would we need all this paraphernalia to protect our patients against an imaginary foe? When going through a hospital and seeing wounds filled with pus that have been made under the spray and dressed according to Lister's method, it is really amusing to listen to the many explanations given to account for the presence of the pus and the unhealthy action. Some little detail, we are gravely told, was accidentally omitted, and this is the result. Explanations which can only be compared to the reasons given by those estimable people possessed of more goodness of heart than of wisdom when trying to account for the non-restoration to health of some one who had something the matter with him, and had been prayed over by the brethren possibly for months together. Herbert Spencer, in his essay on the coming slavery, says that when railways were first opened in Spain peasants standing on the track were not unfrequently run over, and that the blame fell on the engine-drivers for not

stopping, rural experiences having yielded no conception of the momentum of a large mass moving at a high velocity ; and he goes on to speak of a political momentum which, instead of diminishing or remaining constant, increases. I think we might recognize a momentum in antiseptic theories—a momentum that seems to be carrying us into irrational and absurd practices, that after a time we shall be compelled to give up, but not without the loss of prestige and influence with the public. According to the present rate of progression we shall soon, when called upon to attend a case of midwifery, be compelled to retire to our bath-rooms, wash and scrub in disinfectant solutions, don a fresh suit of disinfected clothes, and, like the Romish priests, when called to administer the communion at a person's residence, we shall go forth, preceded by couriers to clear the way and open doors, etc., not daring to touch a door-bell knob, lest, possibly, an unclean mendicant has first handled and defiled it.

Would it not be better if our line of action were directed against more tangible sources of septic poison than the atmosphere we breathe. Instead of becoming machines, let us more carefully and intelligently avoid known sources of danger. We, as general physicians, must attend diphtheria, scarlatina, peritonitis, etc., but if we do, before going from these cases to attend confinements, let us take those measures to ensure against conveying them to our patients which every-day experience proves to be sufficient, rather than inflict upon our patients a long detail of preventive treatment, which is repugnant, troublesome and costly, both as to time and money. More than this, these very precautions which some would induce us to take to insure the safety of our patients may be made indirectly to increase this danger by rendering us less careful in avoiding known sources of contagion. When in Philadelphia a year ago, in conversation with Prof. Levis, he expressed himself as a thorough believer in Listerism. He told me that when going through Sir Joseph Lister's wards Lister remarked to him that his wards were æsthetically dirty but surgically clean. That simply proved that it was possible by great care and by the use of every precaution to keep a surgical wound clean in an æsthetically dirty

ward; but it shows the tendency to trust to these more showy and formal means of prevention, and to neglect the ordinary rules of cleanliness, which have been rightly said to rank next to godliness. Let us first pluck the beam from under our finger nails, and then, perhaps, we shall see more clearly to pluck out the mote from the atmosphere.

Dr. Kennedy said he did not believe in treating a natural process as if it were pathological. He spoke against the use of the spray, etc., in labor, and thought that antiseptic injections were very seldom needed. The giving of these injections by the physician was lowering him to the position of nurse. He had read of poisoning following the use of injections of solution of bichloride of mercury.

Dr. Campbell endorsed Dr. Kennedy's views. During his 23 years of practice he had attended 1,700 cases of midwifery, and only had six cases of septic trouble, using only ordinary precautions. Most of the cases of septic poisoning were among the better classes.

Dr. A. A. Browne said he had never seen antiseptic midwifery carried out. He thought the main things to attend to were cleanliness and having fresh air. In the Vienna hospitals the fresh air was heated before going through the wards.

Dr. Shepherd said that of late years the term antiseptic treatment had a wider meaning than Listerism. Lister himself says that the spray is the smallest part of the treatment. Fifty per cent. of deaths used to follow amputation of the leg; now the death rate is five or six per cent. The case is not, Did a number do well *without* antiseptics? but, Do all? He has notes of 20 major operations dressed antiseptically without a death, and all but one healed by first intention.

Dr. Trenholme, in over a thousand cases of midwifery he attended, never had a case of septic poisoning, and only had two deaths—one from shock after delivery by forceps in a woman with a deformed pelvis; the second, a woman who got up and walked in the snow a few hours after delivery. He attributed his success to following, as far as he could, Dr. Goodell's teaching, which was to have his patients walk from the room they are

confined in into the room they intend remaining in during convalescence ; also, getting the woman to sit up every day for a few minutes. This was done to favor expulsion of clots, etc. He was also very particular to see that the uterus, after delivery, was completely emptied of all membranes.

Dr. Campbell said he always orders his patients to use an ordinary chamber instead of the bed-pan, thereby necessitating her sitting up.

Cases in Practice.—Dr. Campbell related a case of a gentleman who had gonorrhœa over two years ago, and who, about a week after marrying a perfectly healthy lady, had a recurrence of a discharge similar to his old gonorrhœa. Dr. Campbell asked, Would this be called a gonorrhœal discharge and be infective ?

Several gave it as their opinion that it was a case of non-specific urethritis, such cases not being rare in newly-married men.

A child without nipples.—Dr. Kennedy described this condition lately seen by him in a boy ; no rudimentary glands could be made out.

Dr. Shepherd said that more of such cases were recorded where deficiency was only on one side.

Stated Meeting, May 1st, 1885.

T. J. Alloway, M.D., 1st Vice-President, in the Chair.

Case of Suppurative Tubercular Peritonitis simulating Ovarian Tumor.—Dr. Gardner read the following paper on this case :—

S. B., æt. 23, unmarried, domestic servant, belonging to a remote country district north of the Ottawa River, who had lived in the city during the previous six months, was sent to me about last midwinter by my friend Dr. George Ross for examination, as the suspicion of pregnancy had arisen in consequence of extensive abdominal enlargement. She admitted a pregnancy terminating at six or seven months a year and a half

previous. She could give no definite account of the date at or about which the present abdominal enlargement began, but her mistress noticed it three or four months previous. It had rapidly increased since then. The girl complained of abdominal pain; menses had been absent for three or four months; general strength, health and appetite had declined, and she had become emaciated. The tongue was red.

Examination.—The belly much enlarged; the skin below the navel presenting recent pinkish striæ, as well as old silvery streaks. Well-marked fluctuation over the whole of the anterior and antero-lateral aspects of the abdomen. Dullness on percussion over the same area. In the lumbar region (flanks) and epigastrium the bowel note present. No firm or solid part to be felt anywhere. The anterior aspect of the abdomen quite uniform. The perineum slightly lacerated and the posterior vaginal wall partially prolapsed. The uterus, measuring two inches, pressed upwards and forwards, lay immediately behind the pubes. The patient was admitted to the Montreal General Hospital and kept under observation for a few days, when it was found that she had fever of septic type, the temperature at times running very high, with profuse sweating and occasional attacks of vomiting. During this interval she was seen by Drs. Fenwick, Ross, Roddick, Shepherd and J. C. Cameron, who concurred in my diagnosis of suppurating ovarian cyst. Another symptom, red blush and œdema of the central anterior part of the abdominal wall, seemed to support the view. Operation was resolved on, but delayed on account of the difficulty in communicating with the girl's relations, so far distant from the city.

Operation.—The ordinary incision for ovariotomy was made, but on reaching the peritoneum no separation of parietal from visceral layer could be made; the knife entered the collection of fluid, passing through what seemed to be a thickened, closely adherent cyst wall. The fluid was amber-colored, contained flakes, and in the last portions an obvious admixture of pus. The cyst wall did not collapse as the fluid escaped, but appeared to be adherent everywhere, even to the bottom of the pelvis. Acting on this view and with the concurrence of my friend

Prof. Roddick, who was assisting, I decided to make no attempt at separation of the supposed cyst, but to drain and irrigate, as affording the patient the best chance. A large glass tube was passed through the wound into the Douglas pouch, and irrigation practised every two hours, night and day. At first weak carbolized water, then corrosive sublimate solutions, and finally solutions of iodine, were used for this purpose. The general condition at once improved, and this was maintained for a period of ten days. Fever diminished and appetite improved. After a few days the reflux water during irrigation contained enormous quantities of fibrinous, flaky material. Soon, however, her condition again declined. Temperature ran high; sweats were profuse. The discharge always somewhat fœtid, became more so. Soon after the operation the patient suddenly developed a cough with expectoration, which soon became purulent, and was at times bloody. Three weeks after the operation a large rubber drainage-tube was passed through the Douglas pouch and out by the vagina, being carried a few inches beyond the vulva. This did no good. She gradually sank, and died exhausted six weeks after the operation. Two days before death she complained of sore throat, and on examination the fauces, tonsils and posterior wall of the pharynx were found to be covered with a diphtheritic membrane. Until the autopsy, I adhered to the original diagnosis of suppurating, universally adherent, ovarian cyst. Dr. R. J. B. Howard, acting pathologist to the Hospital, made the autopsy. I append his report: —"On opening abdomen a large globular mass presents, of the size of a man's head, occupying false pelvis; this and the parietes are everywhere covered by a grey, rough membrane about one-eighth of an inch thick. The transverse colon is firmly adherent to the upper surface, and is also bound tightly down to the liver. A collection of pus is found below and by the side of the spleen, and another, smaller, under left lobe of liver in middle line. The anterior peritoneal cavity is thus converted into a suppurating cyst, extending from liver down into true pelvis, nearly filled by the mass, which is found to consist of all the intestines, except the transverse colon, closely matted toge-

ther by recent slight adhesions, which are studded with miliary tubercles. The cyst wall is apparently much older than the inter-intestinal adhesions, and looks like an unhealthy granulating membrane. The walls and viscera of true pelvis are covered by the same membrane. The great omentum has quite disappeared; but no doubt had been spread out over the intestines, and formed part of the membrane covering them. All the abdominal viscera adherent to one another and to parietes. Liver fatty; contains a few gray granulations. Kidneys contain a few gray granulations. Lungs universally adherent; abundantly studded with gray granulations. Tonsils and pharynx—surface gray and sloughy-looking. No loss of substance; same appearance involves œsophagus opposite cricoid cartilage, and about four inches lower down."

Remarks.—The principal interest of the case lies in the diagnosis. It well illustrates how difficult it may be to definitely fix the real nature of an abdominal fluctuating tumor. The fact that the abdominal enlargement was uniform, central, and occupying the anterior and antero-lateral parts of the abdomen, to the exclusion of the flanks, where the clear percussion note shewed the presence of bowel, added to the difficulties. A similar case occurred to my colleague, Dr. Fenwick, some years ago. The same error of diagnosis was made by all who saw the case. This patient died some months after operation, probably also of tuberculous disease, as she developed a pleuritic effusion before leaving the hospital. Other similar cases are reported by Spencer Wells, Erich, Ewing Mears and Atlee. The well-known dangers of tapping ovarian tumors, in my opinion, make that procedure for obtaining fluid for microscopical examination unjustifiable, especially as there is no concurrence of opinion of microscopists as to the certainty of that means of diagnosis. Happily, the treatment in my case leaves no room for regret, as under the circumstances it was the very best that could have been applied. It clearly prolonged life, and if the peritonitis had been simple it would almost to a certainty have saved the life of the patient.

Case of Partial Epilepsy.—Dr. Mignault read the following paper :

The occurrence of cases of transient or partial epilepsy are by no means rare, and, though less striking and, so to speak, impressive than the convulsive forms, are still worthy of study, and from the mildness of the morbid process seems much easier to arrest, and perhaps cure, than the former variety. The multiplicity of manifestations of this disease may often mask its presence, and, as in the case here cited, may almost be overlooked by the patient himself.

On the 12th of last February I was summoned to see M. H., aged 40. He occupied a private ward in the Hotel Dieu, and came to be treated for what is called biliousness. I gave him the usual treatment, a purge, and subsequent doses of nitro-muriatic acid, and the patient left the hospital, apparently feeling much relieved, and returned to his home in Boston.

About the 25th of the same month patient returned, and complained of renewed attacks of biliousness. The patient, a few days afterwards, mentioned incidentally that he suffered from occasional attacks of vertigo and fatigue. It was only some days later that he described, after several questions, the nature of these vertiginous attacks. The seizures occurred as follows :— On a sudden, without preliminary warning, he would lose consciousness, and, being possessed of a fixed idea, would set to work to execute it mechanically. He generally fancied that it was necessary for him to go to bed ; accordingly he would seek some room where he knew a bed was situated, and would undress and get into it. As often happened, being a teacher in an orphan asylum, he would manage to crowd himself into a child's cot, and would, to his intense disgust, suddenly resume consciousness and find himself cramped and stiff from the exertion. On another occasion, while waiting for a train at a railway station, he started off to walk along the track. As he crossed a bridge, stepping from sleeper to sleeper, he was loudly shouted at by several persons, but he was still unconscious, and pursued his way for about four miles, when he was both astonished and amazed to find that he had wandered so far away from his destination.

This feat was all the more remarkable from the fact that my patient was very lame from hip disease in childhood, and wore a boot with a cork sole which replaced the shortening of the diseased leg. He states that the duration of these fits is from a few minutes to an hour, and that they generally occur in the daytime and very irregularly. He only has had them since the last two years, and they occur simultaneously with disordered digestion and torpid liver. No premonitory symptoms ever occurred. From the statements of eye-witnesses, the patient at these times becomes very pale, the eyes are wide open and have a fixed expression. He answers quietly and reasonably any question which may be addressed to him, and will often even apologize for the trouble he is giving. The patient, who is an intelligent and serious man, avers that he has not the slightest consciousness of what occurs.

Upon questioning patient as to his history, he states that at 18, while a student at college, he suffered from epileptic seizures of the convulsive form, and that they disappeared after two years of treatment. They did not interfere with his general health; and he attributed them to fatigue after severe study. Patient belongs to a healthy family, and there is no trace of any neurotic disposition.

The pathology of epilepsy came to my aid in the diagnosis of this case. Assuming, with modern authority, that epilepsy is the result of sudden and acute anæmia of the cortex, with congestion of the medulla, we may presume that in this case there is simply acute anæmia of the cortex, without notable congestion of the bulb. As it is probable that the conscious centres are located in the cortex, and, moreover, that all the mandates of the mind are communicated to these convolutions, it is easy to explain the absence of conscious control and the occurrence of mechanical actions. The cortex—the bond of union between mind and matter, so to say—paralyzed, and the great ganglia in perfect condition, the movements are simply like the reflex spinal movements, and are called on in precisely the same manner. The diagnosis of this case seemed at first rather difficult, and I was inclined to believe it a case of catalepsy. The absence

of rigidity, however, and the history of the patient, led me to class it among those cases termed "partial epilepsy," and in a late number of the *New York Med. Abstract* several such cases are cited and thus named. The treatment employed ultimately was based upon my pathological ideas, and then alone was it successful. I tried at first the anti-epileptic mixture of Brown-Sequard for two weeks, and the attacks were of frequent occurrence. I then thought of treating the cerebral anæmia, and gave the patient ½ gr. nitro-glycerine thrice daily. I followed in this the idea of Hammond of New York. The results were excellent. The fits ceased, and patient passed three weeks without a single seizure. At the end of that time he noticed a copious deposit of lithates in the urine, with a diminution of that secretion, and the following day two seizures occurred; both were very brief in their duration. I prescribed a mixture of pot. bicarb., and all went on well as before.

The patient left shortly afterward for Boston. At last accounts he was still well, and whenever the urine became loaded he had recourse to the potash mixture, and so the fits were averted.

Dr. Henry Howard took exception to the name of the paper, and said that it should be called a mild form of epilepsy. Another form was the marked epilepsy. He knew of a gentleman who has had attacks of this nature for ten years, but is not aware of the fact. He has a momentary loss of consciousness, with slight quivering of the muscles of the face. Another, a lady, has attacks which are not more severe than the aura of an ordinary epilepsy. She suddenly feels a something run up from the foot to the heart, and in a few minutes is perfectly well again. The Italians have been writing much on epilepsy. They show that cortical epilepsy, when the lesion is in the motor area, always is accompanied with convulsions, which begin in the side of the face opposite to the brain lesion. The arm is next affected, then the leg, and last the trunk. When the lesion is in the peripheral or lower centres, then there are no general convulsions. In a pure case of cortical epilepsy, there must be biting of the tongue and relaxation of the sphincters.

Dr. Campbell, who has on several occasions spoken of the

great benefit of nitro-glycerine in epilepsy, again mentioned his continued success with it, and related one or two cases where a wonderful change for the better has followed its administration.

Stated Meeting, May 15th, 1885.

T. J. Alloway, M.D., 1st Vice-President, in the Chair.

Atmospheric Materies Morbi.—Dr. Henry Howard read a somewhat lengthy paper on this subject, of which the following is a brief abstract :

We don't know, and perhaps we never will know, what were the characteristics of primordial matter, whether if atoms or molecules, or both together. Physical science teaches us that all the different degrees of matter have their own peculiar structure, consequently each has its own peculiar phenomenon, force or function, such as psychic, motor and sensorial. . . . . Now what do we mean by the term " atmospheric materies morbi " ? The great physical scientist, Prof. Tyndall, demonstrated by the most conclusive experiments that the atmosphere was filled with floating matter, which, under favorable circumstances, produced a very low living animal organism, but he did not demonstrate whether it was mineral, vegetable, or animal matter, or all three combined. . . . . The question naturally suggests itself, how so many persons fall victims to these germinal diseases—typhoid fever, cholera, etc. Dr. Howard dwelt at some length upon the action of the toxic germ of cholera causing paralysis of the vaso-motor nerves, and concluded by saying that he thought the treatment must tend towards restoring those nerves to their normal state.

Stated Meeting, May 29th, 1885.

T. J. Alloway, M.D., 1st Vice-President, in the Chair.

Dr. R. J. B. Howard exhibited the following pathological specimens :

Atheroma of Aorta—Infarct in Spleen—Granular Kidneys.—The heart showed a moderate degree of calcification of the aortic valves, normal in other respects. Aorta showed very advanced atheroma, there being all degrees from slight yellowish sub-intimal deposit to extensive calcification of the inner and middle coats ; also many spots where the intima had been destroyed, laying bare the middle coat, which was calcified. In one place two of these "atheromatous ulcers" communicated by a passage running under the intima, admitting a pencil. The spleen had a large infarct raising the capsule, marked off from the surrounding tissue by a dense, yellow, fibrinous capsule. The substance of the infarct was of a dull reddish brown color, soft and friable, apparently structureless, and looking like a decomposing blood clot. The kidneys were a little smaller than normal. Cortex shrunken, surface typically granular, surface tough on section.

The patient had a spot of softening in the pons. This specimen was in Dr. Wilkins' possession. The condition of the aorta, etc., was not suspected during life.

Dr. Wilkins said this patient, aged about 73, came to hospital with paresis of the left side, contracted pupils and mental derangement. The muscles of the thumb of the left hand were wasted, the right less so. Five or six days before death, left-sided hemiplegia set in, which could not be accounted for at the time, but which the *post-mortem* made clear. He sliced the brain, getting nothing abnormal till the pons was reached. Here, to the left of the median line, was found a spot of softening the size of a pea, due, no doubt, to a piece of fibrin from the aorta or a little plate becoming separated and carried till lodged there.

Malignant Disease of the Uterus.—Dr. Howard exhibited this for Dr. Armstrong. The cervix was gone ; all the remaining tissues were involved, as were also the parts about the bladder. Both ureters were enormously dilated, from being blocked at the lower end. The pelves also were greatly distended. There were no signs of peritonitis.

Dr. Armstrong said he saw the patient first in the beginning of January. Was sent for on account of excessive metrorrhagia. The case was easily diagnosed, and the chloride of zinc paste applied. A slough formed and came away. She got about till April 1st, when he was again sent for to stop another hemorrhage. The paste was again applied. He was sent for a third time for this trouble last Wednesday, but on arriving she was dead. A late symptom was incontinence of urine from the infiltration about the neck of the bladder and urethra. For the last five or six days no urine came away. She never suffered much. The patient's sister had just recently died of the same disease.

Dr. McConnell then read a paper on "Cholera and the Comma Bacillus." After introducing the subject, he stated that all epidemics of cholera have their origin in the region about the delta of the Ganges, in India ; and the course pursued by those which have reached this country has usually been northwestward through Afghanistan and Persia, over the Caucasus, or along the Caspian to Russia ; thence through Northern Europe to England and across the Atlantic. The epidemic which threatens us this year is taking a shorter route. It left its seat about 1880, prevailed in Arabia in 1881 and 1882, ravaged Egypt in 1883 and France in 1884,—and this year it is epidemic in Spain, and should England be visited the probability of its being conveyed to this country will be great. The natural history, character, etc., of the bacteriaceæ were then briefly sketched. Bacteria were first discovered in 1683 by Leewenhock, a Dutch microscopist, but the knowledge we now possess has been gained chiefly by investigations made during the last twenty years. The names of those prominent in this field of science were then given. Bacteria had been discov-

ered associated with the following affections, and have, in some, been satisfactorily demonstrated as being the cause :—Anthrax, septicæmia, pyæmia, osteo-myelitis, malignant œdema, erysipelas, glanders, relapsing fever, typhoid fever, variola, cow-pox and sheep-pox, measles, diphtheria, malarial fevers, syphilis, gonorrhœa, endocarditis, croupous pneumonia, pertussis, trachoma, pterygium, tuberculosis and some others,—and recently Pasteur has discovered a micro-organism in hydrophobia, and by attenuating the germs and inoculating dogs with them has rendered the latter insusceptible to the influence of the most potent rabid virus. Reference was then made to the work of those who had during the past forty years made search for the cholera germ, and the arguments in favor of the germ theory of this and other infectious diseases were given. The work of Dr. Koch was then referred to in detail. The character of the comma bacilli, their peculiarities of development and the influence of drugs upon them given, and their occurring only in the intestinal canal, and contents mentioned. The experiments of Drs. Reitsch and Nicati, who successfully inoculated animals with the comma bacillus, was subsequently confirmed by Dr. Koch. The fact that Drs. Finkler and Prior of Bonn, and Drs. Klein and Gibbes of London, found comma-shaped bacilli in sporadic cholera and dysentery, and that they were found in stale cheese by Deneke and in the saliva by Muhler and Lewis, was met by Dr. Koch and his followers by insisting that morphological criteria alone are not sufficient to show that the bacilli are identical. Their physiological characters must be similar ; under cultivation the mode of vegetation and the colonies, etc., of the above are quite different from the cholera bacillus, hence they are distinct species. The bacillus said to have been found in the blood by MM. Strauss and Roux, Dr. Koch pointed out, were the " blood plates " often found in some febrile diseases. He (Dr. McC.) thought the report of Drs. Klein and Gibbes, of the English Cholera Commission, rather confirmed Koch's discovery than otherwise. They found the comma bacillus in all cases, but looked upon others as *post-mortem* occurrences. They also found straight

bacilli, but Mr. Watson Cheyne, in the discussion which followed their report to the Royal Medical and Chirurgical Society, stated that they were at one time straight, then curved and sometimes spiral, but whatever its morphological change is, it invariably exhibits the same actions and characters under cultivation. The detection and cultivation of the comma bacillus would enable us to recognize the earliest cases of cholera or an incipient epidemic. In regard to treatment, the fact that the bacilli do not develope in acid media or below 60° F. would support the advocates of acids and cold as treatment, although opium must still be the sheet-anchor. As the bacilli are destroyed by drying, dry heat would form the best disinfectant. The inoculations by Dr. Ferran in Spain were then referred to. He (Dr. McC.) said, as the bacilli had been found in the intestines only, not in the blood, and one attack of cholera did not usually protect from subsequent ones, it would be interesting to learn the method adopted and what measure of protection is afforded.

Dr. Wilkins said that five or six weeks ago Prof. Billings brought him a test-tube containing the Asiatic cholera germs in a beef-tea and gelatine solution, also one with the cholera morbus germs. From the shaking they received both were liquified, so that their peculiar and very different behaviours could not be observed. The cholera morbus preparation was very fœtid, the other much less so.

Dr. Kennedy suggested that, as the men about copper works were known to be rarely attacked with cholera, the salts of copper should be tried as a remedy.

Dr. Hy. Howard had seen three epidemics—one in Ireland and two in Canada. Each epidemic appeared to be less severe than the previous one. The salts of copper had been used in all these epidemics, but were not found of more benefit than other astringents.

Dr. A. L. Smith asked if during the last epidemic in this city the water reservoir was then at the head of Elizabeth street, and was the water pumped up to it from the river opposite to the city.

Dr. Kennedy said it was.

Dr. Hy. Howard said that 42 years ago the reservoir was a large wooden vat at the corner of Notre Dame and Bonsecours streets, the water being pumped into this from the long wharf. It was supplied by wooden pipes. There were then no water-closets in the houses.

Dr. Trenholme said that if cholera came, he intended giving his patients large quantities of water along with spirits and camphor.

Dr. R. J. B. Howard said he had recently heard a discussion as to its treatment in London. Application of hot water to the back and abdomen, and hot alcoholic drinks with diluted sulphuric acid were strongly recommended. Enemata of carbolic acid, corrosive sublimate and nitrate of silver were said also to be of great service.

Dr. Reed said that more than likely it was the acid fumes about copper works which preserved the workmen from attacks of cholera.

Stated Meeting, June 12th, 1885.

E. H. Trenholme, M.D., 2nd Vice-President, in the Chair.

Cancer of Rectum with Secondary Affection of Stomach.—Dr. R. J. B. Howard exhibited the stomach and intestines of a patient who had recently died at the Montreal General Hospital. The history of the case is as follows: James W., aged 63, had for some time had pain referred to bladder, and was sent into the hospital under Dr. Fenwick, on suspicion of having stone in the bladder. In December, 1884, he began to suffer pain over pubes, slight and limited in area, increased on lying down. This pain increased steadily in intensity, and in April last patient gave up work on this account. At this time there was frequent micturition, both day and night, but urine presented nothing unusual. He now began to lose flesh rapidly. Some three weeks before admission he had some retching, and on three occasions vomited. On admission into the hospital June 2, '85, the above symptoms were present. It was found that the stream

during micturition was sometimes arrested, and that the act was attended by pain. No stone was detected in the bladder, and as the urine contained some pus, and his prostate was enlarged, he was put on treatment for cystitis. Nothing was discovered when examining prostate per rectum, except the enlargement of that gland. Two days later he had an alarming attack of collapse, and recovering from this, symptoms of pneumonia appeared, of which disease he died on June 9th. Before this a hard tumor was detected in the epigastrium, which was believed to be malignant disease of the pylorus, or possibly the liver. The man was much emaciated, and had a very cachectic appearance.

Necropsy.—Pneumonia of left lung and œdema. In abdomen all the glands in omentum were enlarged, some the size of a walnut, hard and firm. The gastro-colic omentum was puckered up and contained a large nodular mass. Ascending colon bent on itself, and held down by a large mass of new growth, which appeared to originate in the glands of the meso-colon. Sigmoid flexure turned up and fixed to transverse colon by another nodule of cancerous tissue, and lower down, opposite the third lumbar vertebra, adhered to a large mass formed between the layers of the mesentery. The abdominal viscera were removed *en masse*, and on further dissection an ulcerated surface the size of a man's palm was found occupying the posterior aspect of the lesser curvature of the stomach, and its wall was slightly infiltrated; the pancreas was also involved in this growth. In several other places the walls of the bowel were the seat of similar new growths, usually attacking them from without, and starting from between the layers of the mesentery. All the mesenteric and retro-peritoneal glands were enlarged, firm, and evidently the seat of the same new growth. On the anterior wall of the rectum, corresponding to a mass the size of a bantam's egg, seated in wall of rectum and adherent to the bladder just above the prostate was an ulcer the size of a ten-cent piece, having raised, rolled ridges, and a somewhat depressed base. The ulcer was about four inches from anus, and no enlarged glands were found

* Since this report, a microscopic examination of the primary nodule shows this to have been of the nature of true scirrhus and not epithelioma.

below this Veins of prostatic plexus filled with old clot. Arteries normal. Bladder normal, with exception of enlarged prostate.

Dr. R. J. B. H. remarked that this was another of those cases where there was extensive disease of the stomach without symptoms. The original disease, without doubt, commenced in the rectum, and extended upwards to the stomach through the glands. He also said that it is most unusual for malignant disease of the rectum to spread so rapidly, and from so slight a local affection to become general carcinoma. The symptoms caused by moderate enlargement of the prostate were more prominent than those caused by the extensive malignant disease.

Case of Tetany.—Dr. Stewart read the following paper on this case and exhibited the patient :

A. C., aged 39, through the kindness of Dr. McConnell, consulted me about two months ago, complaining of diarrhœa and "spasms of the face, arms and legs." His diarrhœa began seven years ago, and has been more or less constant ever since. The spasms of the muscles of the limbs and face, which are of an intermittent character, first troubled him about five years ago. During the late American civil war he served as a private soldier throughout many of the Virginia campaigns. He had three attacks of malarial fever, and for eighteen months suffered from chronic dysentery ; and it was not until he moved to the Western States, after the termination of the war, that he completely recovered from it. He never had either syphilis or rheumatism ; never drank to excess ; worked at his trade (stone-mason) until eighteen months ago, until he was no longer able on account of gradually-increasing general weakness and the stiffness of the muscles of his hands. In 1863 he received a severe scalp wound from a sabre, which healed in a short time. The family history is unimportant.

Patient is tall, emaciated and anæmic, with an anxious and careworn expression. About once a month the muscles of his fingers, hands and arms become the seat of tonic contractions, which generally last from ten to twelve days. The thumbs become adducted and opposed, while the fingers are adducted and semi-flexed. The contractions come at times suddenly, but usually

are slow in making their appearance, and gradually increase in severity day by day up to the tenth or twelfth day, when they suddenly begin to decline, the parts becoming normal in about twenty-four hours. When the spasms are what he calls severe, the adductors of the upper arms become involved, bringing the arms crossed in front of the body, the forearms being usually semi-flexed. For some hours before, and during the whole time that the tetany is present he has a disagreeable feeling of numbness in his fingers. The dorsum of his hands swell and become very painful also during this period. The pain is especially severe when an attempt is made to move the contracted muscles. The muscles of the face are usually more or less contracted at the same time. He has a feeling as if the skin was too tightly drawn across his face. The facial muscles are also the seat of almost constant fibrillary twitchings. The muscles of the lower extremities are only occasionally the seat of spastic contractions; when they are, the feet and toes are in a state of plantar flexion, the feet being turned inwards and the thighs adducted. During the existence of tetany he has diplopia.

The electrical reactions of the nerves and muscles affected are enormously increased. During the past week, while he was suffering from one of his usual attacks, contraction of the facial muscles was induced on the application of galvanism to the facial nerve by a strength of current not exceeding ·25 of a milliampère (measured by Edelmann's galvanometer), while at the present time, when his muscles are no longer rigid, the tetany having passed away, it takes 3 milliampères to produce a similar result. There is a corresponding difference in the reactions of the radial, ulnar and median nerves.

	Normal period.	*Tetany period.*
Facial	3.0 milliampères.	.25 milliampères.
Radial	5.00	1.00
Median	4.25	.50
Ulnar	3.50	.50

Since coming under observation, the two attacks which he has suffered from have not been attended by contraction of the muscles of the lower extremities. On this account their electrical

reactions have not been ascertained. Five milliampères is sufficient to produce tetanic contraction on the shutting of the kathode (K S Te) and on opening the anode (A O Te). There is no change in the normal formula, the K S Z < A O Z. The difference in the reactions of the nerves and muscles to the induced current during the tetany and after it has passed away is not marked. In fact, the interossei require a much stronger current to produce their contraction during the tetany state than during the normal condition. This is plainly owing to the œdema of the hands during the attacks, the œdematous tissues greatly increasing the resistance. The muscles, although flabby, are in a fairly nourished condition. The patellar reflexes are greatly exaggerated during the period of tetany, while after it has passed away it is frequently impossible to produce any contraction of the quadriceps when the patellar tendons are struck. The triceps and biceps reflexes are exaggerated during the tetany period, and absent after the muscles have become normal. No ankle clonus at either period. There is nothing definite to be made out in regard to the superficial and organic reflexes.

The tongue is constantly in a raw-looking state. The appetite, however, is usually fair. He is seldom free from diarrhœa, the average number of stools in the twenty-four hours being usually about six; only very seldom is there one stool in the day. The diarrhœa always moderates when the tetany makes its appearance. The abdomen is constantly distended; stools are large, frothy, semi-fluid, and look like pea-soup. The urine is acid, but normal in quantity, specific gravity 1030; contains great excess of both urea and indican, but is free from albumen and sugar. At times he becomes deeply jaundiced. There is no further evidence, however, physical or subjective, of disease of the liver. The apex of the heart is in the normal position. There is no increase in the cardiac dulness, neither is there is any other evidence of cardiac disease. Nothing abnormal in the respiratory system. There is no relative increase in the number of the white-blood cells; the red appear to be normal. There is no enlargement of the spleen.

Remarks.—We have here to do with a case of chronic diar-

rhœa of some seven years standing, with intermittent tetany of five years' duration. Tetany is a disease which has been known for some years. First described in France by Corvisart, later and more fully by Trousseau, but it is to Weiss and Chovstok of Vienna and Erb of Heidelberg that we are indebted, in the main, for our present knowledge of it. There are three apparently distinct forms of this disease, forms which differ much in the causes which give them origin and in their prognosis, but little in the clinical pictures which they present. By far the most variety common of this disease is known as " rheumatic " or epidemic tetany.

The second variety of tetany is more chronic, and is due to either chronic diarrhœa, prolonged lactation, or other debilitating influences. The third form follows operations for removal of enlarged thyroid glands.

Clinically, these varieties differ somewhat. The so-called rheumatic form being essentially an acute affection, coming on suddenly and terminating usually inside of two weeks, the spastic periods of a few hours' duration intermitting with normal periods. Recovery nearly always occurs. The chronic form, due to debilitating agencies, differs little from the acute form, except in duration. Recovery in these cases nearly always occur also. The so-called surgical variety of the disease generally makes its appearance about a week after extirpation of enlarged thyroid glands, and especially when the subject has been a young female. Many of these prove fatal within a few days, while a number become permanently chronic. Early and complete recovery is very exceptional.

Judging from published observations, tetany is an extremely rare disease on this side of the Atlantic. In England it is equally rare. On the continent of Europe it is quite common, especially in France and Germany. This is true of all forms of the disease. In Vienna, not a winter passes without an epidemic of it, while cases of the chronic and surgical varieties are not at all rare. Up to May 1883, Billroth performed 78 operations for removal of goitres, 12 of which proved fatal, 6 of these deaths being directly due to tetany. In all, there were 13 cases

of tetany following the 78 operations, 6 of which ended fatally. Two of the fatal cases ran a course of upwards of one year, while the remaining four terminated within two weeks.

Pathology.—There is nothing definitely known. In the very few cases where a histological examination of the nervous structures has been obtained after death, no lesion to account for the symptoms present during life could be discovered.

I have in my possession sections of the cervical cord of a young girl who died from tetany two weeks after the removal of an enlarged thyroid gland, the only noticeable change being in the finely granular protoplasm of the ganglion cells of the anterior horns; the granules being considerably larger than they normally are. A few swollen ganglion cells are also noticeable. Simply saying that tetany is due to an exaggerated excitability of the spinal gray matter means nothing. How this excitability is induced remains unanswered. On the theory that the cerebellum is the centre for continuous movements, and the cerebrum for changing movements, Dr. Hughlings-Jackson has advanced the proposition that the phenomena of tetany are best explained by defective antagonism of cerebellar influences. That during the tetanic period the cerebral influences are removed.

To explain how causes, seemingly so diverse in their operation, as "rheumatic influences," diarrhœa, lactation, and operative interferences on the thyroid glands, can induce similar symptoms is very difficult. At one time it was thought that those cases following thyroid removals were due to injury of the recurrent laryngeal nerve during the operation. Cases of tetany, however, follow this operation, no matter what care may be taken in avoiding this nerve; it is therefore fair to conclude that there is no direct causative connection, especially when we take into account the fact that irritation of the recurrent laryngeal nerve from the pressure of tumors does not induce this disease. The active cause in the case reported is undoubtedly the diarrhœa, but whether induced by the direct impoverishment of the nerve centres, or through the constant peripheral (intestinal) irritation, it is impossible to say. The late N. Weiss of Vienna considered peripheral irritation to be the cause of the disease. He believed

that this gave rise to alternate waves of vessel dilatation and contraction. During the former state we have, according to this assumption, the tetany period, while during the latter the muscles return to their normal condition. This theory might possibly explain cases like the one under observation and those following goitre removals, but it could not apply to the "rheumatic cases."

Treatment.—No medicinal agent has any power in absolutely preventing or diminishing tetany. Billroth speaks favorably of the application of ice to the cervical spine. Erb, Chovstok and Weiss look upon galvanism as the only agent of any real value. Erb believes that it considerably shortens and ameliorates the attacks. He recommends the K A to be applied to the sternum while the A N is to be applied to the diseased parts in succession, including the muscles, main nerve trunks, and the cervical portion of the spinal cord.*

In the discussion which followed the reading of the paper,

Dr. Geo. Ross said he would like to ask Dr. Stewart the mode of death in the fatal cases he had seen. The disease is such a rare one in this country that he had seen but few cases.

Dr. Henry Howard, after alluding to the various disorders of the nervous system allied to tetany, said that in his opinion a more complete anatomical and physiological knowledge of the nervous system is necessary before the exact cause of these cases can be positively known; but he thought that some irritation or inflammation of the vaso-motor nervous system may account for this disease. He had strong hopes that in the near future, with the many workers and varied means of research, the cause of diseases such as cancer, tetany, etc., will be found, and when recognized early, that they may be successfully treated.

Dr. Godfrey had seen several cases of tetany, or a disease like it, during the last fifteen years.

Dr. Shepherd asked why it is that tetany is so much more common on the continent of Europe than in America or England,

* Since this patient was exhibited to the Society, an attack was apparently averted by galvanization of the radial nerves.

epidemics of the disease being unknown in either place, and whether tetany is more common in the dark races, as is tetanus.

Dr. R. J. B. Howard said it was remarkable that two such different diseases as myxœdema and tetany should occur so commonly after extirpation of the thyroid gland. They occur in animals as well as man. He suggested that, where possible, the isthmus only of the thyroid should be removed, as in the 150 experiments of removal of the isthmus, performed on animals by Victor Horsley, none suffered from tetany.

Dr. Wilkins said that although he had never had a case of tetany, he was much interested in the disease, and thought it probably due to irritation of the peripheral nerves, as these cases always follow diarrhœa, removal of the thyroid, or some other lesion.

Dr. Stewart, in reply, said that in the fatal cases he had seen there was spastic contraction of the respiratory muscles and bronchitis. He could not tell the reason of the frequency of the disease in Europe; of course, removal of the thyroid is a very common operation there, and this would account for some of the cases, but not the epidemic form. He had seen 60 to 70 cases in the General Hospital at Vienna at one time. So frequently did this disease follow extirpation of the thyroid, that Billroth had given up operating for bronchocele, except in cases where the tumors endangered life. He was not aware of the disease being known in the West Indies, or that it is more frequent in the negro race. As to the theories advanced to explain its nature, he thought that advanced by Weiss of Vienna the most probable. Weiss looks upon the origin of the trouble as due to irritation of the sympathetic, waves of dilatation and contraction being alternately set up.

Ureometry.—Dr. Reed showed Doremus' ureometer, and illustrated the method of using it. This apparatus is very simple, consisting of one piece only—a bent tube of glass, one arm of which is graduated to represent grains per ounce of urea. The peculiarity of the instrument lies in the fact that a measured quantity of the urine to be tested is projected, by means of a nipple pipette, beyond the bend of the tube, previously filled

with the usual hypobromite solution. Dr. Reed had tested it with a solution of pure urea, and found the readings correct. The price of the instrument is two dollars, and of each test under three cents. Specific gravity beads, as supplied by Parke, Davis & Co., for estimating the density of urine, were also shown and recommended, as being more convenient, simple and portable than the usual urinometers.

Stated Meeting, June 26th, 1885.

T. J. Alloway, M.D., 1st Vice-President, in the Chair.

Case of Extra-uterine Fœtation treated by Electricity.— Dr. Gardner read the following paper on this case :—

Mrs. ——, æt. 38, married 19 years, four pregnancies all to full term, natural labors, slow recoveries. Ever since the birth of her second child, 16 years ago, has suffered from symptoms of uterine disease. The last child was born 9½ years ago. Since then the uterine symptoms have been worse, consisting of pelvic and lumbar pain, bearing down sensations, profuse and protracted menstrual periods and leucorrhœa. The last appearance of menses previous to the symptoms about to be detailed occurred about October 1st, 1884. On the 16th of October a single complete act of coitus occurred, there having been complete abstinence for many months previous and subsequently during the interval before patient's illness. After the 16th of October she did not again menstruate, but had slight discharges of bright red blood, lasting one to two days and occurring at irregular intervals. She suffered from indigestion, nausea with occasional vomiting, and suspected that she was pregnant. On the 20th of December following, my friend, Dr. Gurd, had an urgent message to see her, and on arriving found that she had been suddenly seized with violent pelvic and abdominal pain, vomiting and faintness, amounting almost to collapse ; the pulse was weak and the surface deadly pale. Pain was principally referred to the right iliac region, and here

also marked tenderness and induration were noticed. Next day, the patient seeming to be worse, I was asked to see her in consultation. On vaginal examination the uterus was found to be prolapsed and retroverted, the vaginal portion so low that it lay immediately within the vaginal orifice. To the right of the uterus, and adherent to it, lay a firm mass. Rectal examination merely confirmed the results of vaginal examination. Hæmatocele was considered to be the probable nature of the case. Morphia was freely given to control pain. The symptoms speedily subsided, but never completely disappeared, although she was able to sit up. Two or three weeks later another similar but milder attack occurred. A third and more severe occurred towards the end of January. During this latter, I again saw the lady several times with Dr. Gurd. Five weeks had elapsed between my first and second visits. Meanwhile the doctor, as a result of frequent visits and observations of the progress of the case, of the development of areola and follicles around the nipple and pigmentation of the linea alba and lower part of the abdomen, and because of steady increase in size of the mass in the right iliac region, began to suspect extra-uterine fœtation. In this opinion I could not but concur. There were, however, some doubtful points. The tumor, it is true, had increased in size, but it felt solid; no distinct evidence of fluctuation could be had, no ballotement certainly. On the other hand, the softening and swelling of the cervix had become exceedingly well-marked. The prolapsed vaginal portion lay in the vaginal orifice, the elongated anterior lip projecting through it. Early in February *bruit de souffle* became distinctly audible over the tumor, which now extended upwards to a line drawn transversely on a level with the anterior superior spine of the ilium, and laterally to a line $\frac{3}{4}$in. to the left of the middle line, completely filling the space between these lines and the margin of the pubes below and the crest of the ilium on the right. The most careful and repeated auscultation revealed no fœtal heart sounds. Vaginal examination showed the pelvis to be almost filled by the enlarging mass, together with the swollen, softened and retroverted uterus. I now ventured to

pass the sound, which entered four inches, the concavity being backwards, and seemed to indicate an empty cavity.

The evidence being so strong, we now decided to use electricity. A strong Faradic current—as strong as the patient could bear it—was passed through the tumor. An olive-shaped insulated metallic bulb, coated with chamois leather, was made the terminal of one pole introduced within the rectum, while by an ordinary sponge electrode the other was applied over the tumor in the hypogastrium. The applications were of seven minutes' duration, and repeated daily five times and every other day twice. The immediate effect was to increase the size, pain and tenderness of the tumor. After the third or fourth application the *bruit de souffle* was stilled. In a few days after the cessation of the faradisation, a marked diminution in the size of the mass took place. The pain and tenderness had also markedly subsided. But shortly afterwards labor-like pains and moderate bleeding came on. On the second day of these symptoms, I visited the patient and found the cervix so dilated that I could with perfect ease reach the fundus with my finger. A decidual membrane was being detached from the endometrium, otherwise the cavity was empty. This membrane I peeled off. The bloody discharge ceased in a few days. After this she improved so much that I ventured to consent to her leaving her bed and going to a couch in the same room, but this proved unfortunate, for she immediately began to suffer from what we took to be symptoms of inflammation and suppuration in the tumor. It became very painful, tender and swollen, and presently a red blush with slight œdema of the surface appeared. Temperature rose three or four degrees, and altogether her condition gave us much anxiety for a week or two. These symptoms occurred on the closing days of March and first week of April. During this period, while I was absent in New York, she was seen by my friend and colleague, Dr. Shepherd. The question of incision and drainage of the supposed abscess cavity was seriously considered, but unexpectedly she began to improve in every respect, and a few weeks afterwards was able to leave her bed.

On the 15th June I had an opportunity of visiting and exam-

ining the patient. I found her out of bed, dressed, and able to go down stairs. She was pale and thin, but expressed herself as having a fair appetite and good digestion. She had menstruated twice since the beginning of April; profusely on both occasions. Slight pain of hypogastrium still complained of, increased by exertion. Bladder still irritable. On examination, the tumor in the right iliac region is still present, but greatly reduced in size. Per vaginam, the mass to the right of the uterus is to be felt, but also reduced in size. The uterus is decidedly firmer and smaller, measuring $3\frac{1}{2}$ inches.

Remarks.—That the case now related was really one of extra-uterine fœtation can, I believe, admit of no doubt. The history, symptoms, the suspicions of the patient, the result of pelvic examination, the results of treatment, and, lastly, certain events after the use of the electricity, particularly the labor-like pains, hæmorrhage and expulsion of decidual membrane, combine to form a mass of evidence which cannot be controverted. The induration of the mass was perhaps exceptional, but easily enough accounted for by peritoneal and cellular inflammatory thickening. As regards the particular part or organ in which the fœtation was lodged, there does not seem any reason to doubt that it was (at least primarily) the relatively common tubal variety. The history and previous symptoms further show that the case is no exception to the rule that extra-uterine pregnancy occurs in women advanced in sexual life who have hitherto been sterile, absolutely so, or for a long term of years, and have suffered from pre-existing uterine disease. It is more than likely that there was chronic disease of the Fallopian tubes, with its obvious predisposition to the condition.

Extra-uterine pregnancy justly excites much interest in the medical mind. The difficulty of diagnosis in many cases, the fact that in a goodly number no opportunity has been afforded to make a diagnosis, the patient either not having consulted a practitioner or no examination having been made, the sudden tragic, perhaps fatal termination being the first intimation of the true nature of the case, amply account for this. Within the last five years this interest has become more intense. This is

in part due to the fact of increased activity of discussion of all gynæcological topics, but mainly to the success of certain modern methods of treatment. I have alluded to the difficulties of correct diagnosis. But it is, indeed, doubtful if it be much more difficult to diagnose extra- than intra-uterine pregnancy during the first three months. All who make frequent examinations of the female sexual organs, or who are much consulted in this class of cases, will agree with me that it is often necessary for all but rash men to suspend judgment till, by the lapse of time, a doubtful case is cleared up. The treatment of extra-uterine fœtation by electricity and other agents which have for their object the death of the fœtus, to be successful, must be employed early, preferably between the second and third month, otherwise the fatal rupture so often occurring at this period may not be anticipated. Hence the importance of early diagnosis. Failure to diagnose the condition is doubtless sometimes due to an impression in the professional mind that the condition is extremly rare. This is erroneous. Dr. Garrigues of New York, while preparing a paper on the subject for the American Gynæcological Society three years ago, read the reports of 200 cases all published within four years. In January 1885, Thomas reported to the New York Obstetrical Society his thirtieth case. It is, of course, uncommon, but, compared with many other abnormalities of gestation, it is not so very rare. As in many other conditions difficult of diagnosis, mistakes would be few if it were borne in mind as one of the causes of pelvic symptoms, and, above all, if careful systematic examinations (under ether if necessary), were made.

To Dr. J. G. Allen of the United States we owe the successful employment of the faradic current in extra-uterine pregnancy. His first case occurred in 1869; the second in 1871. Since then, and especially during the last five years, a goodly number of successful cases have been reported, especially in the United States. The galvanic current, applied by puncture and externally by interruptions, has also been successfully employed, but it is more troublesome by whatever method selected, and no more efficacious than the induction apparatus. The dangers of punc-

ture, from inflammation and suppuration of the sac are such as to render it, in my opinion, quite unjustifiable. Notwithstanding these facts, the value of the method is far from being generally appreciated, especially in Britain. The Barnes', father and son, in the first volume of "Obstetric Medicine and Surgery," published in 1884, dismiss it with a notice of a line and a half, giving it no prominence; on the contrary, rather advocating tapping of the cyst with the aspirator needle in preference to any other treatment. A great merit of the faradic current is that it is so easily applied as to be within the capacity of the merest tyro in the therapeutic use of electricity. In the great majority of successful cases, the current has been applied as described in our case. Another great advantage is, that if unsuccessful, it can do little, if any, harm. In case of mistaken diagnosis, if the pregnancy be uterine, the worst result is abortion. Such an occurrence cannot be admitted as an argument of any weight when the probability of the existence of so grave a condition as extra-uterine fœtation is great. The other great step in the treatment of extra-uterine pregnancy is an outcome of the rapid progress of abdominal surgery, and is one of Mr. Lawson Tait's many contributions to that department of surgery. It is for the most part applicable to cases in which suddenly occurring and urgent symptoms of rupture and hæmorrhage are present. It consists in abdominal section, removing the fœtus, clots, etc., ligating the affected tube, and then excising it. The indications then in the treatment of extra-uterine fœtation when diagnosed during the first four months seem clear. If no evidences of internal hæmorrhage be present, the induced electric current is to be used with the object of killing the fœtus. If rupture have occurred, however desperate the spmptoms, the belly is to be opened, and the bleeding point having been secured, the cavity is well sponged out and drained before being closed. The case here reported is offered as a contribution to the literature of the subject, and is, so far as I know, the first reported case treated by electricity in the Dominion.

Discussion.—Dr. Shepherd said when he saw the case there

were evidences of septic trouble. Tait says all these cases are tubal at first; he cuts down and removes the fœtus.

Dr. Hy. Howard said he had only seen one case of extra-uterine fœtation; it came to full term. The tumor was aspirated, followed in 24 hours by peritonitis, convulsions and death.

Dr. Wilkins asked how the electricity caused the death of the fœtus; was it by exciting strong contractions of the muscular structures of the Fallopian tubes?

Dr. Kennedy said that he had seen two cases of extra-uterine fœtation. One of these had been reported to the Society some years ago. In this case the woman came to him about the fifth or sixth month to engage his services. Her appearance was normal, and she felt quite well. At the end of nine months he was sent for, as symptoms of labor had set in; on examination of the uterus, found it empty and the actual condition diagnosed. The case was explained to the patient and operation suggested, but she and her friends positively refused such assistance. The movements of the fœtus were quite lively up to this time, but ceased in a few days, and in a short time after, septic fever setting in, she was sent to the General Hospital. In the hospital she passed per rectum several fœtal bones, sloughing having taken place between the sac and adjacent bowel. This patient died from septic poisoning, and the post-mortem confirmed the diagnosis previously made. The second case came under his notice eighteen months ago. He was asked to see in consultation a patient supposed to have pelvic cellulitis. After examining her, he coincided with the family doctor in this opinion, but on a subsequent consultation he had come to the conclusion that the case was one of extra uterine fœtation. Afterwards, during the absence of his *confrère*, he took charge of the case. The patient had been married before, and had two children by her first husband. The present husband was a strong, big man, with whom intercourse was generally painful. Previous to her illness she had thought herself pregnant, but the menstrual discharge had continued, somewhat altered from the usual flow when about $3\frac{1}{2}$ months in gestation, and while dusting down the stairs, she was seized with a sudden severe pain in the abdomen, which

almost caused her to faint. She was prescribed opiates and rest, and after a few days was up again. About ten days after, she had a second attack, and later a third. The last seizure was accompanied with a profuse flow and discharge of a membrane resembling the decidua. Abortion was supposed to have occurred, followed by pelvic inflammation. Although pelvic cellulitis was diagnosed, Dr. Kennedy has now no doubt that the primary condition was one of extra-uterine fœtation; the character of the seizure and the subsequent symptoms being such as are observed in tubal pregnancy. Fortunately, death of the fœtus no doubt ensued, and the subsequent inflammation had encysted its remains. This patient was a long time ill, but afterwards recovered. A tumor yet remains on the right side, and coitus is still painful.

Dr. Trenholme had met with one well marked case where the fœtus perished before its movements were felt. The patient becoming free from symptoms, went to the seaside, where she passed several small bones per rectum. There remained indications of induration. She has been in perfect health ever since. Another case he was called to see, where the fœtus was as the sixth month. On examining the uterus, it measured 7 or 8 inches, was empty, but on the left side he found a bulging, and thought the case to be one of tubo-uterine fœtation. He scraped over the bulged wall with a curette, and in 24 or 36 hours this was followed by expulsion of the fœtus. He thinks the electricity kills from shock, not from exciting muscular contraction, as most likely the first seizure corresponded with the rupture of the tube, allowing the contents of the sac to fall into the abdomen, where there would be no muscles constricting it.

Dr. Alloway said he had read of a woman dying at the age of 75, and in whose abdomen fœtal bones were found at the post-mortem examination. When 22 years of age she had had symptoms of extra-uterine pregnancy.

Dr. Gardner said that Tait found by examination that all cases were first tubal. Tait confines his operations to cases where rupture has occurred. Electricity is safe and simple to use. In this case electricity might have been used earlier. The electricity kills by shock to the child's heart. Most cases are

right-sided. He believed there was not much doubt but that Dr. Kennedy's second case was one of extra-uterine pregnancy.

Dr. Gurd mentioned that their patient was doing well, being able now to take short walks.

Dr. Cameron asked if menstruation in this case had been abnormal. He had a case eight years ago where the woman suffered greatly at each period as if from inflammation of the Fallopian tubes. Might not these cases be caused by narrowing of the tube by contraction?

Dr. Gardner said this explanation was a feasible one.

Dr. Trenholme said that a cellulitis with contracting bands might destroy the patency of the tube.

Dr. Wilkins said that a chronic diseased condition might destroy the cilia of the mucous membrane of the tube, and so account for the fructified ovaries not being sent down into the uterus.

Gynæcology.—Dr. Lapthorn Smith read a short paper entitled "Notes on Gynæcology," being some observations made during a month's visit to the Women's Hospitals of New York. He began by referring to the great frequency with which the major gynæcological operations are performed, a frequency, however, which seemed to be generally justified by the results. Ovariotomies and hysterectomies were of daily occurrence, those of them which took place at the Woman's Hospital being performed in detached cottages, under the most perfect sanitary conditions. He thought that they were sometimes done in the face of fearful odds against success, the consequence being that the death rate was rather high. He spoke of the skill and coolness of the operators, and the splendid training of the assistants and nurses. Although the operations were not done antiseptically in the strictest sense, yet every precaution was taken to insure cleanliness. Dr. Hunter takes especial care not to allow a single drop of blood to enter the peritoneal cavity when performing hysterectomy; the peritoneum not being opened until all bleeding from the incision in the abdominal wall had been arrested. When the uterine tumor has been drawn through the opening, it is immediately wrapped in a carbolized towel, in which it is held, and the edges of the wound are enfolded in warm

carbolized towels. Ether was the only anæsthetic used. The operations for lacerated cervix and lacerated perineum are performed with still greater frequency ; the former being done not only for the purpose of closing the rent, but still more often as a rapid method of removing the hypertrophy and inflammatory exudation of subinvolution. The operator made it a rule to be satisfied with nothing short of the complete removal of the cysts formed by the diseased nabothian glands, digging down and removing indurated tissue almost as far as the internal os. The needles used were short, round, and slightly curved, having one surface ground flat near the point ; and for sutures, a No. 26 pure silver wire attached to the end of a plaited silk thread was generally employed. The operation for lacerated perineum is also very frequently done ; in many cases for the cure of rectocele and displacements of the uterus. The reader stated that he frequently met with cases of prolapsus uteri in his practice, in which the vulva was so large that no from of ring pessary could be retained ; all such cases were suitable for operating. He also remarked that in these two operations the scissors and tenaculum have completely taken the place of the knife and forceps. Two other instruments which he found in general use were the Wylie dilator and the Thomas' blunt curette, their advantages and immunity from danger he set forth at some length ; nevertheless, it is better to keep the patient anæsthetized. The reader then related the various uses to which the tamponnade of the vagina or columning is put to, and stated that it has very largely taken the place of solid pessaries, especially where there is an inflammation in or about the displaced organ. He stated that the introduction of cotton tampons soaked in glycerine or glycerine of tannin and the use of the hot-water douche have marked a new era in the treatment of pelvic cellulitis, subinvolution of the uterus, and other inflammatory affections of the generative organs. He concluded by describing a case under Emmet's care, in which that distinguished operator had intentionally made a vesico-vaginal fistula for the cure of chronic cystitis which had been otherwise intractable. After three or four months the cystitis was cured, and he closed the fistula without much difficulty.

Anuual Meeting, October 9th, 1885.

T. G. Roddick, M.D., President, in the Chair.

The annual meeting of this Society was held on Friday evening, October 9th, a large attendance of members being present.

The following were proposed for membership: Drs. R. F. Ruttan, W. McClure, F. G. Findley, S. Gustin and D. W. Eberts.

PATHOLOGICAL SPECIMENS.

Dr. Trenholme exhibited an *Ovarian Cyst* and *Two Extirpated Uteri*, and gave the following particulars:—

The ovarian cyst was removed from Mrs. I., of Shawville, aged 42, of spare habit and nervous temperament. Nine years married; no children. Her illness began 16 years ago, when her bladder troubled her. Feeling of pressure, pain in the back, inability to sit; bowels constipated; insomnia; menses always irregular, but for the last six months has had no flow. At present time, pains are not so severe as formerly, and chiefly felt in the back and over the womb. Upon examination, the uterus is found high up and pressed above the pubis, but in the median line. A large, dense tumor is felt to the back of the womb, filling up the brim of the pelvis. This tumor is firm to the touch, smooth and uniform. On the left antero-lateral aspect of the tumor, a small body is found connected with it. This was thought to be (as you now see it is) the left ovary. The tumor itself reached almost to the umbilicus. The depth of the uterine cavity was three inches. The tumor reached nearly as high as the umbilicus in the centre of the body, and well back toward the spinal column. The diagnosis was doubtful: at first inclined to ovarian cyst, originating with displaced ovary, but subsequently, from consideration of the history and the doubtful mobility of the uterus, etc., this was changed to uterine fibroid. As nothing special depended upon a more accurate diagnosis, the removal of the tumor was clearly indicated. The operation for this purpose was performed 12th Aug., 1885, assisted by Drs.

Kennedy, Cameron, Perrigo and Reddy. There were also present Drs. Lyon, Morrison and Saunders. The usual median incision, three inches long, was made, and when the tumor was reached its real character was apparent. There were many adhesions both to the peritoneum and the uterus, those to the latter quite strong. About O iv of clear fluid were removed by Fitch's trocar, which, by the way, disappointed me in its working. A few bleeding points were secured by hemp ligatures and the sac of the cyst removed. The abdominal incision was closed and dressed in my usual way. The patient did well, the chief after trouble being due to her nervous condition and some irritation of the bladder. Though rather prematurely, she left for her father's home in Iroquois on the 3rd September, just three weeks and one day after the operation.

Extirpation of a Cancerous Uterus.—This specimen was removed from a lady 42 years of age. The general appearance of the patient was that of good health. For some months past she had been suffering from pains in the pelvis and left groin, which had become so severe that she consulted me about her case early in August of this year. Upon examination, the os was found to be cancerous, and the disease had invaded the upper part of the vagina on the left side to a slight extent. The depth of the uterus was about three inches, the organ movable, and in normal position. Believing the diseased tissues could be removed with some chance of success, and of possible temporary relief—at the patient's repeated and earnest request,—the extirpation of the uterus per vaginam was performed on 20th Aug., 1885—seven weeks yesterday. In this, the first and only operation of the kind in Canada that I know of, I was assisted by Drs. Kennedy, Cameron and Perrigo—a number of medical men and medical students being also present. *Operation* —After reaching Douglas' pouch, the fundus was brought down by means of a strong vulsellum ; the right broad ligament was then ligated in small segments and divided. In this there was no very great difficulty, but when I attempted a similar procedure with the left ligament, to my dismay I found it so densely infiltrated with the disease that I had to content myself with dividing the re-

maining structures, guided by the sense of touch alone. There was but slight hemorrhage, and after the removal of the uterus I scooped out a quantity of cancerous tissue with Thomas' serrated spoon. There was some slight hemorrhage a few hours after the operation, which was easily controlled; and but for the escape of the peritoneal fluid, which has given the patient a great deal of trouble, and also kept her weak, she has done well, and is now able to work around her room. I trust, in a few days, she will return to her home. One remarkable feature in this case was the almost entire absence of suffering from the operation itself. The opening of the cavity of the peritoneum, as in this operation, becomes a serious contra-indication to its performance, inasmuch as it cannot be closed by sutures on account of the infiltrated state of the tissues rendering impossible an approximation of the edges of the wound.

Dr. Gardner congratulated Dr. Trenholme on the success of the operation, but thought the case not a good one to select for this operation, as there was ample evidence of infiltration of the broad ligament. In such cases, gouging or scraping is all that should be attempted.

Drs. Kennedy and Hingston also spoke against operating in these cases.

Dr. Alloway gave a short description of a similar case under his care. He thought operating unjustifiable.

Dr. Shepherd asked Dr. Trenholme if his patient was in a better condition now than before operating, or if she was going to live longer. Dr. T. said she would not probably live longer, but she was free from suffering, and therefore better than before the operation.

Fibroid Tumor of Uterus (2 *lbs*).—The second specimen of extirpated uterus is of more than ordinary interest to me, as well as to the profession, because it is the uterus of the first woman who, in January 1876, was spayed for the control of uterine hemorrhage. The first operation gave the patient nearly ten years' lease of a life that was rapidly drawing to a close when the ovaries were removed. In fact, last March she was robust and fleshy, but foolishly undertaking excessive laborious

work, congestion of the uterus was developed, with a distressing train of nerve symptoms that of late threatened a termination of her life. Her attacks of nervous distress occurred every nine days and lasted for nine days, and were followed by loss of flesh and strength. During the attacks the uterus greatly increased in size, and her symptoms were all referable to that organ. As all conceivable treatment, including incision of the tumor, etc., was of no avail, she determined to have the uterus and tumor removed. *Operation*, 24th Sept., assisted by Drs. Kennedy, Perrigo, Cameron and Armstrong, and a number of medical visitors and students being present.—The usual abdominal incision had to be somewhat modified so as to remove the cicatricial tissue of the former wound; this, of course, necessitated the division of a few muscular fibres of the recti muscles. The tumor was firmly packed in the pelvis, and strongly adherent almost all over its surface. The attachments to the bladder were markedly so, and led to the mishap of incising that viscus to the extent of about half an inch. After separating the uterus from its supports, etc., as far as the neck, a wire écraseur was passed around the latter, and tightened just sufficiently to control any hemorrhage. The tumor and uterus were removed by the V incision, (as performed by myself many years ago), in the same way as in the last case operated upon in London, Ont., in May 1883. The flaps were adjusted—after carefully securing all the arteries—by the double-running suture, the material used upon this occasion being the prepared iron silk. The bladder was sewed up in a similar manner. The cavity was cleansed and the wound brought together in my usual way by deep silver and superficial horse-hair sutures. A carbolized gauze pad over the wound, held *in situ* by three short straps of adhesive plaster, completed the toilet. It is now two weeks and two days since the operation, and, as the chart of temperature, etc., shews, her convalescence has been a remarkable one. The bladder has given no trouble, and, from present appearances, it will not be long ere this lady, for the second time, will be restored to the active duties of life.

Nephrectomy (first recorded case in Canada).—Dr. Hingston exhibited a kidney removed by him for hydronephrosis.

The kidney was made up of a lot of cysts, containing, when pressed, a fluid similar in appearance to ovarian fluid, which became of caseous appearance on evaporation. The parenchymatous structure was all gone. No calculus or obstruction was found. The ureter, at the pelvis, was not discernible—nor exteriorly. The lateral operation was employed; there was no difficulty, and but very little general disturbance followed. The patient had suffered from hæmaturia and great pain in the right side.

Dr. Hingston, on being requested, promised to give a paper on this case at the next meeting. Dr. Shepherd, who had also removed a kidney lately, said he would read a paper on his case at the same meeting.

ELECTION OF OFFICERS.

Balloting for the election of officers for the ensuing year then took place, with the following results :—

President—Dr. T. G. Roddick (re-elected).
First Vice-President—Dr. J. C. Cameron.
Second Vice-President—Dr. Geo. Wilkins.
Treasurer—Dr. James Perrigo.
Secretary—Dr. D. F. Gurd (re-elected).
Librarian—Dr. T. D. Reed (re-elected).
Council—Drs. Geo. Ross, Kennedy and Rodger (re-elected.)
Publication Committee—Drs. Kennedy, Geo. Ross, J. C. Cameron, and Bell.

Dr. Roddick thanked the Society for the honor done him, and said that at some future time he would give an address on the history of the Society.

A vote of thanks was tendered Dr. Molson for his past services as treasurer.

Dr. Hingston said that nine years ago, during an epidemic of smallpox, the Society passed several resolutions upholding vaccination, etc. He thought it might do good to endorse these now, and proposed the following resolutions :—

Be it resolved,—That this Society reiterates the opinion expressed nine years ago in favor of vaccination, and considers it to be the duty of every physician to diligently encourage, at the present time, the practice of vaccination and re-vaccination.

Resolved,—That the Secretary be authorized to publish the above resolutions in the city press.